Supreme Court, U.S.
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In The

Supreme Court of the United States

DR. DRALVES GENE EDWARDS,

Petitioner,

v.

BLUE CROSS BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORP.,

Respondent.

On Petition For Writ Of Certiorari
To The Texas Court Of Appeals
For The Fifth District

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

I. Whether the Texas Court of Appeals wrongly concluded (contrary to decisions from other federal and state courts of appeals) that all state law claims for consequential damages against Medicare fiscal intermediaries are preempted under the Medicare Act.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	ii
OPINIONS BELOW	1
JURISDICTION	1
CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED	1
STATEMENT	4
A. The Medicare Act	4
B. Dr. Edwards' claims under state law	6
C. The lower courts' treatment of Edwards' state law claims	9
REASONS FOR GRANTING THE WRIT	11
I. Courts are divided on whether the Medicare Act is the exclusive remedy for claims against MACs	11
II. The issue of whether collateral damages may be pursued against a MAC is of national importance	15
III. The case presents no vehicle problems	17
IV. The Texas Court of Appeals' decision was contrary to this Court's precedents and erroneous	17
CONCLUSION	25

TABLE OF CONTENTS – Continued

Page

APPENDIX

Texas Court of Appeals, Opinion (Dec. 29, 2008) ..... App. 1

Texas District Court, 44th Judicial District, Order on Summary Judgment Motion (June 26, 2007) ..... App. 24

Texas Supreme Court, Order Denying Review (June 26, 2009) ..... App. 26

TABLE OF AUTHORITIES

Page

CASES:

Ardary v. Aetna Health Plans of S. Cal., 98 F.3d 496 (9th Cir. 1996) 14, 20, 23

Berman v. Abington Radiology Associates, Inc., 1997 U.S. Dist. LEXIS 12322 (E.D. Penn. 1997) 21

Bodiametric Health Services, Inc. v. Aetna Life & Casualty, 903 F.2d 480 (7th Cir. 1990) 12, 13, 14, 22, 23

Burke v. Humana Ins. Co., 1995 U.S. Dist. LEXIS 20744 (M.D. Ala. 1995) 21

City of Worcester v. HCA Mgm't Co., 753 F.Supp. 31 (D. Mass. 1990) 24

Financial Advisors and Consultants, Inc. v. Cooperative De Seguros De Vida, 106 F.Supp.2d 244 (U.S.P.R. 2000) 24

Grijalva v. Shalala, 152 F.3d 1115 (9th Cir. 1998) 21

Group Health Inc. v. Blue Cross Assoc., 625 F.Supp. 69 (S.D. N.Y. 1985) 24

Heckler v. Ringer, 466 U.S. 602 (1984) ..... *passim*

Hofler v. Aetna US Healthcare of Cal., Inc., 296 F.3d 764 (9th Cir. Cal. 2002) 21

Kaiser v. Blue Cross of Cal., 347 F.3d 1107 (9th Cir. 2003) 14, 22

TABLE OF AUTHORITIES – Continued

Page

Jamaica Hosp. Nursing Home v. Oxford Health Plans, 2000 U.S. Dist. LEXIS 13917 (S.D. N.Y. 2000) 21

Kelly v. Advantage Health, Inc., 1999 U.S. Dist. LEXIS 6903 (E.D. La. 1999) 19, 20

Kelly v. Advantage Health, Inc., 1999 WL 294796 (E.D. La. May 11, 1999) 14

Kennedy v. Health Options, Inc., 329 F.Supp.2d 1314 (S.D. Fla. 2004) 21

Lifecare Hosps., Inc. v. Ochsner Health Plan, Inc., 139 F.Supp.2d 768 (W.D.La. 2001) 12

Livingston v. Blue Cross and Blue Shield of Ala., 788 F.Supp. 545 (S.D. Ala. 1992), *aff'd*, 996 F.2d 314 (11th Cir. 1993) 24

Marsaw v. Thompson, 133 Fed. Appx. 946 (5th Cir. 2005) 13, 23, 24

Midland Psychiatric Associates v. United States of America, 145 F.3d 1000 (8th Cir. 1998) 14

Plocica v. Nylcare, Inc., 43 F.Supp.2d 658 (N.D. Tex. 1999) 21

Reagan v. East Texas Medical Center Regional Healthcare System, 2002 U.S. Dist. Lexis 26847 (S.D. Tex. 2002) 5

Reg'l Med. Transp., Inc. v. Highmark, Inc., 541 F.Supp.2d 718 (E.D. Pa. 2008) 14

Rochester Methodist Hospital v. Travelers Insurance Co., 728 F.2d 1006 (8th Cir. 1984) 24

TABLE OF AUTHORITIES – Continued

Page

Salas v. Grancare, No. 99CA0089 (Colo. App. 1/04/2001) 14

United States ex rel. Body v. Blue Cross and Blue Shield of Alabama Inc., 156 F.3d 1098 (11th Cir. 1998) 5

Wartenburg v. Aetna U.S. Healthcare, Inc., 2 F.Supp.2d 273 (E.D.N.Y. 1998) 21

Wright v. Combined Ins. Co. of America, 959 F.Supp. 356 (N.D. Miss. 1997) 21

Zamora-Quezada v. Health Texas Medical Group, 34 F.Supp.2d 433 (W.D. Tex. 1998) 11

CONSTITUTION:

United States Constitution article VI, clause 2 1

STATUTES AND RULES:

28 U.S.C. § 1257(a) 1

42 U.S.C. § 1395(h) 4

42 U.S.C. § 405(g) ..... *pasim*

S. Ct. Rule 10(a) 15

PETITION FOR WRIT OF CERTIORARI

Petitioner, Dralves Gene Edwards, respectfully petitions for a writ of certiorari to review the judgment of the Texas Court of Appeals for the Fifth District in this case.

OPINIONS BELOW

The Texas Court of Appeals' opinion is unreported. App. 1. The Texas District Court opinion is unreported. App. 24. The denial of discretionary review by the Supreme Court of Texas is unreported. App. 26.

JURISDICTION

The Supreme Court of Texas denied discretionary review on June 26, 2009. App. 26. This Court has jurisdiction under 28 U.S.C. § 1257(a).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The United States Constitution article VI, clause 2, provides that: "This Constitution and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in

every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."

Title 42 United States Code Section 405(g) reads that:

> Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of the Commissioner's answer the Commissioner of Social Security shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the

Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Commissioner of Social Security, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and, in

> any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

STATEMENT

A. The Medicare Act

Medicare, a program administered by the federal government, was created in 1965 at Subchapter XVIII of the Social Security Act, 42 U.S.C. § 1395(h). From Medicare's beginnings, Congress authorized the United States Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid (CMS) to contract with private agencies and organizations to perform claims processing, review, benefit integrity, and payment functions on the federal government's behalf. With simplicity being the order of the day, Congress created only two types

of contractors in its initial Medicare legislation. One type, a "fiscal intermediary," served the Medicare Part A community. The other, a "carrier," served the community in Medicare Part B. The designations remained part of Medicare for almost 40 years.

As a part of the new Medicare Modernization Acts of 2003, comprehensive changes to the Medicare program began. Congress ended the historical distinction between fiscal intermediaries and carriers and, in their place, created a new contracting entity, the Medicare Administrative Contractor (MAC). In so doing, Congress designed the MAC to perform contractor functions simultaneously for Part A and Part B. Congress further designed six broad categories of MAC functions, including payment determinations, making payments, beneficiary education and assistance, provider consultative services, communication with providers, and provider education and technical assistance. Congress also made changes to the standards and language governing statutory liability and indemnification for MACs. Under the new changes, the MAC administers the distribution of Medicare funds and has no financial stake in whether a Medicare claim is denied or approved, because any payment for claims is made from the Federal Supplementary Medical Insurance Trust Fund. *See Reagan v. East Texas Medical Center Regional Healthcare System*, 2002 U.S. Dist. Lexis 26847 at *18 (S.D. Tex. 2002). The Medicare program is paid for by the Health Care Finance Administration. ("HCFA"). *See United States ex rel. Body v.*

Blue Cross and Blue Shield of Alabama Inc., 156 F.3d 1098 (11th Cir. 1998).

B. Dr. Edwards' claims under state law

Dr. Edwards is a licensed physician in the State of Texas, who had a thriving medical practice in Dallas in the early 1990s. About 90% of his patients were enrolled in the Medicare program. His unique practice involved free transportation for his patients and making house calls on the elderly. After being featured in the USA Today newspaper in October 1996, as "one of the few doctors in America making house calls on the elderly," his practice soared and he became one of the highest billing doctors to Medicare in the area.

For most years, Blue Cross paid between 95% and 100% of the claims submitted for payment from Dr. Edwards. However, in 1997, after receiving a letter from Blue Cross stating that he was being placed on a 100% prepayment review, virtually 100% of the claims submitted were denied for code CO-50. Code CO-50 specifically provides that "any services deemed unreasonable and medically unnecessary are not covered and the medical provider is not reimbursed."

Although medical necessities are covered under Medicare, Blue Cross categorically denied medical conditions such as breast cancer, congestive heart failure, and diabetes. When Dr. Edwards sent these same patients to other doctors, Blue Cross paid those

doctors for the same types of medical claims that were denied as to Dr. Edwards. Furthermore, two independent board certified Internal Medicine Specialists reviewed Dr. Edwards' claims and concluded that all the medical conditions were covered under Medicare and should have been paid.

Becoming suspicious of the motives behind the continued denials by Blue Cross, Dr. Edwards conducted a "good faith and integrity test" when he instructed a physician he employed to apply for a Medicare Group number. Dr. Edwards deliberately left his name off of the original application. Blue Cross granted the group number, and about 300 claims were submitted under the group number without Dr. Edwards' name on them. Blue Cross paid 98% of the claims. One month later, Dr. Edwards added his name to the group, and Blue Cross denied 100% of the claims with identical medical conditions that were paid under the group number without his name.

Because Dr. Edwards felt targeted by Blue Cross, he requested a face-to-face meeting to see why his claims were being denied at a rate ten times higher than the national average. In November 1997 at a meeting between Blue Cross and Dr. Edwards, eleven claims were reviewed that had been previously denied as "non-covered services and not medically necessary." Their medical director told Dr. Edwards all these claims were covered services under Medicare and should have been paid, but they did not have a "signature" on his progress notes. (Medicare does not

require a signature for payment of a claim in a private practice.) He advised Dr. Edwards to sign his progress notes, resubmit the claims, and they would be paid. Dr. Edwards signed his progress notes and resubmitted the claims. They were denied again as being non-covered services and not a medical necessity.

This wanton behavior led Dr. Edwards to believe that Blue Cross had denied the claims for payment without ever reviewing them, a mandate of the carrier for a prepayment review to be authentic.

On administrative review, the ALJ concluded that Dr. Edwards' claims were covered and they should have been paid even though Blue Cross denied 96% of the claims in the appeals process. The ALJ's decision, combined with Blue Cross's actions established that either: (1) Blue Cross denied the claims without reviewing them; (2) Blue Cross reviewed the claims but did not know the medical conditions were not covered (highly unlikely); or (3) Blue Cross reviewed the claims and intentionally and willfully denied them for a predetermined outcome.

In 2003, Dr. Edwards sued Blue Cross and Blue Shield of Texas (hereinafter "Blue Cross") in state district court. Dr. Edwards alleged that Blue Cross engaged in a fraudulent scheme that deliberately targeted 40 of Medicare's "top billers" for systematic elimination. The scheme involved the denial of almost 100% of Dr. Edwards' claims without regard to the merits of each medical condition. Dr. Edwards alleged

that the review, if it ever took place, was fraudulent, and it had a predetermined outcome.

Moreover, the complaint alleged that Blue Cross demonstrated a "reckless disregard of their obligations", "criminal conduct" and "fraud" that directly caused Dr. Edwards to close his practice. The complaint further alleged that Blue Cross had caused irreparable harm to Edwards, his reputation and his career. The Edwards' complaint did not, however, request damages for an illegal denial of Medicare payments, it raised only state law breach of contract and tort claims.

C. The lower courts' treatment of Edwards' state law claims

The case filed against Blue Cross and Blue Shield of Texas – and not the Government, its employees or officers – was removed to federal court in 2005. The federal court remanded the case, finding lack of diversity or federal question jurisdiction.

On remand, Blue Cross filed a "No Evidence" Motion for Summary Judgment, alleging lack of subject matter jurisdiction by the district court, sovereign and absolute immunity, limitations and federal preemption.

The district court granted Blue Cross's "No Evidence" Motion for Summary Judgment without stating its grounds. App. 26. In fact, the court granted the summary judgment request in a one-page order.

At issue in the Texas Court of Appeals was whether Dr. Edwards' state law claims were preempted by the Medicare Act. The court first noted that under section 405(g) of the Act, the sole avenue for judicial review of all claims arising under the Act was in federal district court only after the exhaustion of administrative review. Recognizing that Dr. Edwards' claims arose under state law, the court concluded that the claims could be preempted only if they were "inextricably intertwined" with a Medicare benefits determination.

The court recounted decisions from federal courts of appeals where state law claims were deemed inextricably intertwined with Medicare reimbursement. Concluding that Dr. Edwards' claims were similar to those confronted by the federal courts of appeals, and that a state judge would have to review each of Edwards' Medicare denials in order to determine the state law tort and breach claims, the court ultimately held that Dr. Edwards' claims were preempted.

The court also addressed Dr. Edwards' argument that his case was distinguishable from those in the federal courts of appeals because those plaintiffs had not finished the administrative review process. Edwards had argued specifically that he had completed and won the vast majority of his administrative reviews of Blue Cross's Medicare denials. In response to those arguments, the court stated that Congress had entirely foreclosed judicial review after exhaustion of administrative review and

an adverse decision. In other words, the court believed that consequential damages are always an unavailable remedy (even in the state courts) for adverse Medicare determinations by fiscal intermediaries. Therefore, the court affirmed the dismissal of Dr. Edwards' state law claims.

The Texas Supreme Court denied discretionary review without opinion on June 26, 2009.

REASONS FOR GRANTING THE WRIT

I. Courts are divided on whether the Medicare Act is the exclusive remedy for claims against MACs.

The Supreme Court has held that the appropriate inquiry in determining whether a claim is preempted by the Medicare Act is whether the claim "arises under" the Act. *Heckler v. Ringer,* 466 U.S. 602, 614-615 (1984). If a claim arises under the Act, it must be filed in federal district court only after the exhaustion of administrative remedies. 42 U.S.C. § 405(g).

Whether a claim "arises under" the Act is determined by one of two tests enunciated in *Heckler.* First, a claim arises if "both standing and the substantive basis for the presentation" of the claim is the Act. *Heckler,* 466 U.S. at 615; *Zamora-Quezada v. Health Texas Medical Group,* 34 F.Supp.2d 433 (W.D. Tex. 1998). In other words if the Act is cited by the plaintiff in bringing the claim then it obviously arises

under the Act. *See, e.g., Lifecare Hosps., Inc. v. Ochsner Health Plan, Inc.*, 139 F.Supp.2d 768, 771 (W.D.La. 2001).

The second test, and the one relied on by the court of appeals, occurs where a claim is "inextricably intertwined" with Medicare benefits even though the claim arises under a different provision of law. *Heckler*, 466 U.S. at 614, 624. In applying this standard, it does not matter how the plaintiff characterizes his claim. If "at bottom" the plaintiff seeks recovery of Medicare benefits, then the claim arises under the Act. *Id.*

The Supreme Court has clearly held that the nature of the relief sought by the plaintiff is the determinative factor in deciding whether a suit is preempted by the Medicare Act. If the plaintiff seeks recovery of Medicare benefits, then the claim arises under the Act. *Heckler*, 466 U.S. at 614, 624. If the plaintiff seeks declaratory or injunctive relief which has the effect of determining a future claim for benefits, the claim is "inextricably intertwined" with a claim for benefits and arises under the Act. *Id.*

Several federal courts of appeals have held that all claims relating to Medicare are preempted under the Act. In *Bodiametric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480, 487 (7th Cir. 1990), the Seventh Circuit concluded that a party could not avoid implicating the Act "simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits."

Addressing the claim that the court was foreclosing all avenues for persons seeking to sue fiscal intermediaries outside of the Medicare Act, the court noted that:

> By enacting the exclusive review provisions of the Medicare Act, Congress expressly limited the remedies that can be sought by dissatisfied claimants from fiscal intermediaries. While this may, in some cases, foreclose avenues of relief generally available to civil litigants, it is also the system Congress clearly intended to implement. Any decision to modify this aspect of the system must be made by Congress, not by the courts.

Bodiametric, 903 F.2d at 490.

In *Marsaw v. Thompson*, 133 Fed. Appx. 946 (5th Cir. 2005), the Fifth Circuit was confronted with the issue of whether a suit alleging racial discrimination, various torts, and breach of contract claims still "arise under" Medicare. The *Marsaw* court first held that the "sole avenue" for judicial review of claims involving Medicare is § 405(g) of the Medicare Act. That section requires exhaustion of administrative review and an adverse decision. *Id.* at 948. Because the claimant in *Marsaw* had succeeded on his Medicare reimbursement claims through administrative review, the court held that he could obtain no further relief. *Id.* In other words, the court held that all claims involving Medicare are inextricably intertwined and unable to proceed.

Other courts have held that "*Bodiametric* and subsequent cases holding that claims for consequential damages resulting from adverse decisions by Medicare carriers are 'inextricably intertwined' with claims of benefits," stand for the proposition that all claims for consequential damages involving Medicare are prohibited by § 405(g). *See, e.g., Reg'l Med. Transp., Inc. v. Highmark, Inc.*, 541 F.Supp.2d 718, 729 (E.D. Pa. 2008); *Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107, 1112 (9th Cir. 2003); *Midland Psychiatric Associates v. United States of America*, 145 F.3d 1000 (8th Cir. 1998).

In direct conflict with these cases are courts holding that not all consequential damages claims against MACs are prohibited and preempted by the Medicare Act. These courts have reasoned that claims not seeking Medicare reimbursement are not inextricably intertwined with the Act and may proceed against fiscal intermediaries. *See, e.g., Ardary v. Aetna Health Plans of S. Cal.*, 98 F.3d 496 (9th Cir. 1996); *Kelly v. Advantage Health, Inc.*, 1999 WL 294796 (E.D. La. May 11, 1999); *Salas v. Grancare*, No. 99CA0089 (Colo. App. 1/04/2001).

The Texas Court of Appeals has contributed to this circuit split by holding that, while unfortunate, plaintiffs bringing claims derived even collaterally from Medicare reimbursement are completely foreclosed by § 405(g). Indeed, the court concluded that because Dr. Edwards exhausted his administrative remedies and obtained a *favorable* ruling that his Medicare claims were wrongfully denied, § 405(g)

entitled him to "no other relief" even though Blue Cross may have committed state torts and breaches of contract. App. 17.

There is no benefit to allowing this issue to percolate further in the lower courts. The circuit split is square and will not be resolved without this Court's intervention. Moreover, without this Court's resolution of the issue, many claimants may simply quit filing claims against MACs in their respective districts knowing that any claim will be futile. Thus, rather than further percolation, the well of collateral damage claims against MACs may dry up completely. For these reasons, the Court should rectify the split between the various lower courts. *See* S. Ct. Rule 10(a).

II. The issue of whether collateral damages may be pursued against a MAC is of national importance.

The impact to the Nation's health care system, if MACs are immune from all damages when issuing erroneous and malicious Medicare denials, cannot be overstated. This case is a prime example. Dr. Edwards was maliciously placed on the 100% review list by the fiscal intermediary, Blue Cross, because he was one of the top billers of Medicare in his region. Placing Dr. Edwards on the 100% review list ultimately put Edwards out of business, and the Dallas area lost another primary care physician. Since Dr. Edwards was unable to seek consequential

damages, Blue Cross has escaped liability and can continue to target primary care physicians with no consequence.

In fact, in cases such as Dr. Edwards', MACs have every incentive to erroneously deny Medicare claims. In a choice between renewing a Medicare contract by reducing the number of Medicare payouts or reducing emergency room visits and long term hospitalizations, the MAC will undoubtedly choose the former. The already challenged present health care system needs team players, not profiteers. By shielding MAC with unlimited immunity, courts will allow them to continue as profiteers with no incentive to reduce medical costs overall.

This issue affects the one group that this country can ill afford to lose: the Primary Care Physician ("PCP"). Doctors who work 6-7 days a week to fill the void of patients too sick and poor to seek specialists should not be penalized by MAC prepayment review or a lack thereof. The decline of PCPs is very real. Allowing MAC profiteers to eliminate unwanted PCPs for their bottom line, undermines the integrity of the Medicare system, and ultimately this country's health system as a whole.

Also, uncertainty has permeated throughout the country on the question of whether malicious Medicare denials by MACs can be pursued outside the Medicare Act. The Court's guidance is needed to resolve the uncertainty on such a significant issue.

III. This case presents no vehicle problems.

This case presents no procedural defects that would prohibit the Court from ruling on the split and the significant issue of whether MACs are shielded from all consequential damages under the Medicare Act.

First, while the decision arose from the state court level, it addresses a fundamental federal Constitutional question. Namely, whether state law claims are preempted by the Medicare Act. Both the Supremacy Clause and the Medicare Act questions are well within this Court's prerogative to decide.

Secondly, the preemption issue was the sole basis for the lower court's decision. Although the lower court addressed state questions on summary judgment evidence and jurisdiction, those questions were decided beneficially to Edwards and have not been pursued by respondent. The dismissal of Edwards' suit against respondent was based solely on one issue – whether the Medicare Act preempted Edwards' state law claims. The question is therefore squarely presented.

IV. The Texas Court of Appeals' decision was contrary to this Court's precedents and erroneous.

The Texas Court of Appeals is incompatible with this Court's decision in *Heckler v. Ringer*, 466 U.S. 602, 615 (1984). In *Heckler*, the Court held that although § 405(g) "is the sole avenue for judicial

review of all 'claims arising under' the Medicare Act," not all claims related to Medicare denials "arise under" the Act. *Heckler*, 466 U.S. at 615. In order to arise under the Act, the *Heckler* Court believed a claim must either seek Medicare reimbursement or be "inextricably intertwined" to Medicare. *Id.*

The lower court's holding that "the type of remedy sought is not strongly probative of whether a claim falls under [the Medicare Act]" cannot be reconciled with the test of *Heckler*. Indeed, the type of remedy is the best indicator of whether a claim is inextricably intertwined. The claim here, of course, arose under state law and was not seeking Medicare reimbursement, thus, it did not arise under the Act.

The court of appeals also reasoned that Dr. Edwards' suit was "inextricably intertwined" with a claim for medical benefits and arose under the Act because it would involve judicial review of Blue Cross's decision making process in denying benefits claims. App. 17. But Dr. Edwards never asked for review of the Medicare denials in this suit. The review the court of appeals decried was already conducted successfully through the administrative review process.

In this suit, Dr. Edwards claimed that his placement on the 100% review list was a way for Blue Cross to cut Medicare spending in order to renew their Medicare carrier contract with the federal government. In order to decide Dr. Edwards' state tort and breach of contract claims, a lower court

would not need to revisit every denial of Medicare benefits. Rather, it would review whether the motives of Blue Cross in placing Edwards on the 100% list were proper.

Seen in this light, the court of appeals' holding that recovery of Medicare benefits is the exclusive remedy for claims against a fiscal intermediary under the Act is nonsensical. A claim for benefits arising under the Act is, by definition, a claim against the Government and one for which the carrier is not liable. Claims "arising out" of the Act are limited to such claims for benefits, and are subject to limited judicial review in federal court precisely because they are claims against the Government. Neither the Act nor the regulations address non-benefit claims against a MAC for tortious conduct.

Dr. Edwards' claims do not "arise under" the Medicare Act, nor are they "inextricably intertwined" with claims for medical benefits, because he was not, "at bottom" seeking Medicare benefits. Edwards had already received benefits through the exhaustive administrative appeals. He further sought foreseeable consequential damages he incurred when he was unjustly forced to close his medical practice as a proximate result of Blue Cross's fraudulent conduct.

Remarkably similar to Dr. Edwards' case is *Kelly v. Advantage Health, Inc.*, 1999 U.S. Dist. LEXIS 6903 (E.D. La. 1999). There the federal court found that the plaintiff's state law claims were not

preempted by the Medicare Act, and remanded the case to state court. The court stated:

> Nothing in *Heckler* compels a reading of the phrase "arising under" to encompass all state-law claims that relate to a denial of benefits, especially when these claims do not seek reimbursement or provision of Medicare benefits. Unlike the plaintiffs in *Heckler*, petitioner's claims do not "at bottom" seek reimbursement of Medicare benefits. In fact, plaintiff eventually received all of the requested benefits during either his first or second hospitalization. There are no Medicare benefits to be reimbursed or provided either now or in the future. Rather, plaintiff seeks damages for state law torts, which he alleges were inflicted by defendants as a result of their delay in granting the requested benefits. Moreover, contrary to defendants' assertion, the test for determining whether the claim arises under the Act is whether it is "inextricably intertwined" with a claim for benefits, not with the Act itself. Here, plaintiff is not seeking Medicare benefits, and thus his state law tort claims are not "inextricably intertwined" with a claim for Medicare benefits.

Kelly v. Advantage Health, Inc., 1999 U.S. Dist. LEXIS 6903 at *12-13.

Federal courts have consistently held that not all claims against Medicare Administrators are inextricably intertwined. For example, in *Ardary v. Aetna Health Plans of Southern California*, 98 F.3d 496 (9th

Cir. 1996), state law claims for wrongful death and misrepresentation against an intermediary were upheld even though the claims were predicated on the failure to authorize a benefit. Other courts have likewise allowed state law claims to continue against a MAC despite argument that they are prohibited by the Medicare Act. *See, e.g., Hofler v. Aetna US Healthcare of Cal., Inc.*, 296 F.3d 764 (9th Cir. Cal. 2002); *Grijalva v. Shalala*, 152 F.3d 1115 (9th Cir. 1998); *Kennedy v. Health Options, Inc.*, 329 F.Supp.2d 1314 (S.D. Fla. 2004); *Jamaica Hosp. Nursing Home v. Oxford Health Plans*, 2000 U.S. Dist. LEXIS 13917 (S.D. N.Y. 2000); *Plocica v. Nylcare, Inc.*, 43 F.Supp.2d 658 (N.D. Tex. 1999); *Wartenburg v. Aetna U.S. Healthcare, Inc.*, 2 F.Supp.2d 273 (E.D.N.Y. 1998); *Wright v. Combined Ins. Co. of America*, 959 F.Supp. 356, 364 (N.D. Miss. 1997); *Berman v. Abington Radiology Associates, Inc.*, 1997 U.S. Dist. LEXIS 12322 (E.D. Penn. 1997); *Burke v. Humana Ins. Co.*, 1995 U.S. Dist. LEXIS 20744 (M.D. Ala. 1995).

The court of appeals' attempt to distinguish Edwards' case from the multitude of cases permitting suits for damages against MACs on the ground that those cases involved suits by patients rather than by healthcare providers cannot hold water. *See, e.g., Jamaica Hosp. Nursing Home v. Oxford Health Plans*, 2000 U.S. Dist. LEXIS 13917 (S.D. N.Y. 2000). But more importantly, the distinction is contrary to the express language of the Medicare Act itself, which applies the same administrative and judicial review requirements equally to "any individual" bringing a

claim that arises under the Act. 43 U.S.C. § 405(g). The Act simply does not discriminate, nor permit a construction under which a healthcare provider's tort claims against a MAC are deemed to arise under the Act, but a patient's tort claims against a MAC do not.

The court of appeals cites *Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107 (9th Cir. 2003) as limiting the holding in *Ardary* to patient tort claims and calls it "a case very similar to *Edwards*." App. 15. In fact, the claims in *Kaiser* were dismissed solely because the healthcare provider failed to go through the administrative process. *Kaiser*, 347 F.3d at 26. Because the exhaustion of that administrative process is a jurisdictional requisite to a suit, the *Kaiser* court could not properly address the provider's claims. In any event, the plaintiff in *Kaiser* styled its claim as one for damages rather than benefits, and it was clear that the plaintiff's damages included recovery of benefits. The recovery of benefits is of course, a paradigmatic example of a claim inextricably intertwined with the Medicare Act. *Kaiser*, 347 F.3d at 23.

The other cases the court of appeals relied on were similarly distinguishable. In *Bodiametric Health Services, Inc. v. Aetna Life and Casualty*, 903 F.2d 480 (7th Cir. 1990), the claimant had sued for Medicare benefits in addition to consequential damages, and did so without first seeking administrative review. As in *Kaiser*, the suit in *Bodiametric* fell squarely within *Heckler's* holdings that administrative review is a jurisdictional requisite to suit, and that a claim seeking recovery of benefits arises under the Act.

Heckler, 466 U.S. at 614, 624, 637. Indeed, the Ninth Circuit has expressly rejected the reading of *Bodiametric* given by the court of appeal in this case:

> Contrary to *Aetna* and *Arrowest's* assertions, *Bodiametric* should not be taken to imply that private Medicare providers and their representatives cannot be held responsible in their individual capacity for tortious acts committed in the context of the denial of Medicare benefits.

Ardary, 98 F.3d at 498.

The Fifth Circuit's decision in *Marsaw v. Thompson*, 133 Fed. Appx. 946 (5th Cir. 2005), is similarly distinguishable from *Edwards*. In *Marsaw*, the claimant succeeded in recovering benefits in the administrative review. However, the plaintiff filed suit in *federal* court alleging that the review process was unconstitutional, and added supplemental state law claims for consequential damages. The Fifth Circuit did *not* hold that the plaintiff's state law claims arose under Medicare; it held that the plaintiff's federal constitutional claims about the legality of the review process arose under the Act.

The Fifth Circuit decided that federal courts had jurisdiction to hear such claims only when benefits had been *denied*. *Id.* (citing *Weinberger*, 422 U.S. at 758 n.6). But nothing in *Marsaw* implies that state-law claims for damages other than benefits could not be brought in state court. *Marsaw's* dismissal of the federal claims simply had no impact on its decision

not to exercise supplemental jurisdiction over the state law claims. More importantly, *Marsaw* itself distinguished fraud claims from the run-of-the-mill claims alleging the erroneous denial of Medicare benefits. *Id.* (citing *Rochester Methodist Hospital v. Travelers Insurance Co.*, 728 F.2d 1006 (8th Cir. 1984) for the proposition that a fiscal intermediary who commits fraud acts beyond the scope of its authority is not immune from suit).

Several courts have considered whether state law claims for tort damages against fiscal intermediaries are permitted, and found that the Medicare Act allowed such claims. *See, e.g., Brooks,* 116 F.3d at 1383; *Livingston v. Blue Cross and Blue Shield of Ala.*, 788 F.Supp. 545, 548 (S.D. Ala. 1992), *aff'd*, 996 F.2d 314 (11th Cir. 1993); *City of Worcester v. HCA Mgm't Co.*, 753 F.Supp. 31, 38 (D. Mass. 1990); *Group Health Inc. v. Blue Cross Assoc.*, 625 F.Supp. 69, 76 (S.D. N.Y. 1985); *Financial Advisors and Consultants, Inc. v. Cooperative De Seguros De Vida,* 106 F.Supp.2d 244 (U.S.P.R. 2000). This entire line of cases would be rendered meaningless if the court of appeals is correct in holding that recovery of Medicare benefits is the exclusive remedy available against MACs, because Medicare contractors like Blue Cross are never liable for those benefits anyway.

The state court of appeals decision that Edwards' state law claims were preempted was incorrect in light of the foregoing cases allowing state claims to go forward and in light of this Court's decision in

Heckler that not all claims involving the erroneous denial of Medicare benefits arise under the Act.

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

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AFFIRMED; Opinion

[SEAL]

In The
Court of Appeals
Fifth District of Texas at Dallas

No. 05-07-01281-CV

DRALVES GENE EDWARDS, Appellant

V.

BLUE CROSS BLUE SHIELD OF TEXAS, A DIVISION OF HEALTH CARE SERVICE CORP., Appellee

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On Appeal from the 44th Judicial District Court
Dallas County, Texas
Trial Court Cause No. 03-06872-B

OPINION

(Filed Dec. 19, 2008)

Before Justices Moseley, Richter, and Francis
Opinion By Justice Moseley

Appellant, Dralves Gene Edwards, M.D., sued appellee Blue Cross Blue Shield of Texas (Blue Cross), alleging he was a Medicare provider and that Blue Cross, a Medicare Part B carrier, had wrongfully denied almost all of his Medicare claims in 1997 and 1998. Dr. Edwards did not seek recovery for the

Medicare claims themselves, which he pursued (mostly with success) through the Medicare administrative review process, but sought recovery for consequential damages based on a variety of state law causes of action.

The trial court granted summary judgment in favor of Blue Cross, and Edwards appealed. For the reasons discussed below, we conclude Edwards's pleadings affirmatively show his state law claims are "inextricably intertwined" with Medicare benefits determinations, and are preempted by the Medicare Act. Thus, we affirm the trial court's judgment.

Background

The Medicare Act, 42 U.S.C. §§ 1395-1395iii, is a federally subsidized health insurance program for elderly and disabled persons consisting of several parts. *See Marsaw v. Trailblazer Health Enters., L.L.C.*, 192 F.Supp.2d 737, 740 n.2 (S.D. Tex. 2002). The Act is administered by the Secretary of the Department of Health and Human Services (HHS), through the Center for Medicare and Medicaid Services (CMS). *See RenCare, Ltd. v. Humana Health Plan of Tex., Inc.*, 395 F.3d 555, 556 (5th Cir. 2004). CMS contracts with private insurance companies (like Blue Cross) to administer Medicare benefits. *Marsaw*, 192 F.Supp.2d at 740.[1] Under Parts A and B

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[1] These private insurance companies are known as "fiscal intermediaries" under Part A and Medicare "carriers" under

(Continued on following page)

of Medicare, these private contractors process claims for reimbursement from health care providers and determine whether the expenses are covered by Medicare and whether the services were reasonable and medically necessary. *Id.* If approved, funds are taken from the Federal Supplementary Medical Insurance Trust Fund and paid by the intermediary or carrier directly to the providers for each qualifying service provided to a beneficiary. *RenCare*, 395 F.3d at 558.[2]

Edwards sued Blue Cross on June 30, 2003 for state law breach of contract and tort claims relating to Blue Cross's denial of nearly all of his Medicare

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Part B. 42 U.S.C. §§ 1395h, 1395u. Part A generally covers inpatient medical services, while Part B covers most out-patient services such as doctor visits. *See* 42 U.S.C. §§ 1395d-1395i-5; 1395k-1395w-4.

[2] Although this case involves Medicare Part B, it is important to distinguish Medicare Part C programs. Part C provides a managed care option to Medicare enrollees and is administered by private, managed health care organizations or HMOs. *RenCare*, 395 F.3d at 556. Part C differs from Parts A and B in that it is based on a fixed monthly payment to Part C organizations for providing medical care to Medicare patients. *Id.* 395 F.3d at 556-57. A Part C organization does not review claims from medical providers to determine the amount of allowed reimbursement for medical services; it "receives a fixed amount per month for each enrolled [Part C] patient regardless of the value of services the patient actually receives." *Id.* The organizations may freely enter into contracts with other providers to provide services, but assume all risk of expenses for medical services and maintain arrangements for insolvency. *Id.* at 558-59.

Part B reimbursement claims over a two-year period. He later amended his petition to sue Trailblazer Health Enterprises, L.L.C. Trailblazer removed the case to federal court alleging it acted as a fiscal agent of the Secretary of HHS and removal was proper under 28 U.S.C. § 1442(a)(1), allowing removal by an "officer of the U.S. or any agency thereof, or persons acting under that officer" where the defendant was "acting under color of such office." Edwards then dismissed Trailblazer from the suit and filed a motion to remand. The federal court granted the motion to remand after it concluded Blue Cross did not timely remove the suit to federal court and failed to establish another basis for federal jurisdiction.

The facts are taken from Edwards's live pleading, his sixth amended petition filed a month after he filed his response to Blue Cross's motion for summary judgment.[3] Edwards alleged he was a provider of Medicare services and Blue Cross was the Medicare Part B carrier obligated to reimburse him for medical services he provided to Medicare beneficiaries. Edwards alleged that Blue Cross, in connection with negotiations for its acquisition by Health Care Service Corporation, adopted a program that "targeted doctors who were the largest billers to the Medicare systems in a given area in order to systematically eliminate these physicians from the

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[3] Blue Cross disputes many of the facts alleged in Edwards's petition, but agrees for purposes of review those allegation can be taken as true.

system." The purpose of this program was to improve Blue Cross's standing with the federal government because Blue Cross was "in danger of losing [its] contract with the government regarding [its] Medicare services in Texas." On August 26, 1997, Edwards was notified that he was being placed on a 100% pre-payment review for his Medicare billings. He alleged Blue Cross "negligently" administered the pre-payment review and "fraudulently" denied almost 100% of his Medicare billings over a two-year time frame, forcing him to close his medical practice. Edwards claims he is seeking damages he sustained as a result of the breach of contract and torts he alleges and not under "any derivative claim based upon any assignment of patient benefits."

Edwards alleged he was a third-party beneficiary of Blue Cross's contract with CMS and Blue Cross breached that contract not by placing him on pre-payment review, but by failing to actually review all of his claims and investigate the validity of the services rendered after placing him on pre-payment review. He alleged Blue Cross was "not only liable for the money owed to [him] for the individual bills, but for the foreseeable consequences of their actions."

Blue Cross filed a motion for summary judgment under rule 166a(b), but did not attach any summary judgment evidence.[4] TEX. R. CIV. P. 166a(b). The

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[4] The motion states in the alternative that it is a no-evidence motion under rule 166a(i).

motion raised four grounds for summary judgment: (1) lack of subject matter jurisdiction because Edwards's claims arise under the Medicare Act and must be pursued in the administrative process and federal court; (2) sovereign immunity based on Blue Cross's performance of official functions of the Secretary under its contract as a Medicare carrier; (3) the statute of limitations barred the state law claims and the statute was not tolled while Edwards sought administrative review of the denial of Medicare benefits; and (4) Edwards's state law claims were preempted by the Medicare Act and his only remedy is the administrative review of benefit determinations and federal judicial review of adverse decisions of the Secretary. After extensive briefing, pleading amendments, and motions relating to the motion for summary judgment, the trial court conducted a hearing and signed an order granting the motion for summary judgment without specifying the grounds therefor.

Edwards appeals and brings one issue (with seven sub-issues) arguing the trial court erred in granting summary judgment. *See Malooly Bros., Inc. v. Napier,* 461 S.W.2d 119, 121 (Tex. 1970). The first three sub-issues argue Blue Cross's motion was insufficient to prove any of its defenses because it failed to introduce evidence; a no-evidence motion cannot be used by a defendant to prove affirmative defenses; and the summary judgment can be reviewed only on Edwards's pleadings and evidence. The last four sub-issues argue the trial court had

jurisdiction and Blue Cross failed to conclusively prove each of the affirmative defenses of preemption, sovereign immunity, and statute of limitations.

STANDARD OF REVIEW

We apply well-established standards of review to summary judgments. *See Nixon v. Mr. Property Management Co.*, 690 S.W.2d 546, 548-49 (Tex. 1985) (summary judgment standards of review); *see also King Ranch, Inc. v. Chapman*, 118 S.W.3d 742, 750-51 (Tex. 2003) (no-evidence summary judgment standards of review).

Edwards argues Blue Cross's motion for summary judgment was insufficient because it failed to attach summary judgment evidence. A defendant may "move with or without supporting affidavits for a summary judgment in his favor as to all or any part" of a claim against him. TEX. R. CIV. P. 166a(b). A party may also move for traditional summary judgment based on the pleadings and judicial admissions of the opposing party. *See Swilley v. Hughes*, 488 S.W.2d 64, 67 (Tex. 1972); *Washington v. City of Houston*, 874 S.W.2d 791, 794 (Tex. App. – Texarkana 1994, no writ) ("where the plaintiff's pleadings themselves establish the lack of a valid cause of action, such as the fact that the statute of limitations has run, or if the pleadings allege facts that, if proved, establish governmental immunity, pleadings alone can justify summary judgment and special exceptions are not required"). Pleadings may be used as summary

judgment evidence when they contain statements rising to the level of admitting a fact or conclusion which is directly adverse to that party's theory or defense of recovery. *Judwin Props., Inc. v. Griggs and Harrison,* 911 S.W.2d 498, 504 (Tex. App. – Houston [1st Dist.] 1995, no writ).

Edwards also argues Blue Cross's motion fails as a no-evidence motion for summary judgment because it seeks to establish Blue Cross's own affirmative defenses. To this extent, we agree. A no-evidence motion for summary judgment must attack a specific element of the opposing party's cause of action or defense; it cannot be used to establish the movant's own cause of action or defense. *See* TEX. R. CIV. P. 166a(i) (party may move for no-evidence summary judgment on "one or more essential elements of a claim or defense *on which an adverse party* would have the burden of proof at trial") (emphasis added); *de la Garza v. de la Garza,* 185 S.W.3d 924, 927 (Tex. App. – Dallas 2006, no pet.). We also agree with Edwards that Blue Cross's motion for summary judgment should be reviewed based on his pleadings and the evidence he presented in response to the motion.

We will consider Blue Cross's motion as a motion for summary judgment on Edwards's pleadings. We assume the allegations of fact in Edwards's pleadings are true and indulge all inferences from the pleadings in his favor. *See Natividad v. Alexsis, Inc.,* 875 S.W.2d 695, 699 (Tex. 1994). Summary judgment may be proper if the allegations in the pleading affirmatively

show the claims are barred as a matter of law and the defects cannot be cured by amendment. *See In re B.I.V.*, 870 S.W.2d 12, 13 (Tex. 1994).

Discussion

A. Jurisdiction

We discuss the jurisdiction issue first. Blue Cross asserted in its motion for summary judgment that the Medicare Act deprived the trial court of jurisdiction to hear Edward's state law claims because the state law claims were inextricably intertwined with a claim for Medicare benefits and therefore they arose under the Medicare Act. *See Heckler v. Ringer*, 466 U.S. 602, 615 (1984). Edwards counters that his claims are state law statutory, tort, and contract claims not for the Medicare benefits themselves – he has sought those through administrative appeal under Medicare – but for foreseeable consequential damages arising from Blue Cross's allegedly wrongful denial of the original claims. He argues these state law claims are within the jurisdiction of a Texas district court.

A Texas district court is a court of general jurisdiction and is presumed to have subject matter jurisdiction unless a showing is made to the contrary. *Dubai Petroleum Co. v. Kazi*, 12 S.W.3d 71, 75 ("all claims are presumed to fall within the jurisdiction of the district court unless the Legislature or Congress has provided that they must be heard elsewhere"). Federal district courts are courts of limited jurisdiction and subject matter jurisdiction is never presumed. *Id.*

The Texas supreme court has stated that

> [f]ederal preemption "is ordinarily a federal defense to the plaintiff's suit" but does not ordinarily deprive a state court of jurisdiction. *Metro. Life Ins. Co. v. Taylor,* 481 U.S. 58, 63, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987). As a result, "[t]here are thus some cases in which a state law cause of action is preempted, but only a state court has jurisdiction to so rule." *Romney v. Lin,* 105 F.3d 806, 813 (2d Cir. 1997) (denying rehearing). Consequently, we disagree with the court of appeals' conclusion that federal preemption, without more, would necessarily deprive the trial court of jurisdiction.

Mills v. Warner Lambert Co., 157 S.W.3d 424, 427 (Tex. 2005) (per curiam). In keeping with this analysis, we conclude the trial court had jurisdiction to determine the claims alleged by Edwards and whether those claims were preempted by the Medicare Act. We now review the other grounds for summary judgment to determine if they support the trial court's judgment.

B. Other Grounds for Summary Judgment

The laws of the United States are the "supreme Law of the Land"[5] and "[i]f a state law conflicts with

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[5] U.S. CONST. art. VI, cl. 2.

federal law, it is preempted and has no effect." *Great Dane Trailers, Inc. v. Estate of Wells,* 52 S.W.3d 737, 743 (Tex. 2001). State law may be preempted in three ways: (1) federal law may expressly preempt state law; (2) federal law may impliedly preempt state law where a "statute's scope indicates that Congress intended federal law or regulations to occupy the field exclusively"; or (3) federal law may impliedly preempt state law where state law actually conflicts with federal law because it is impossible for a private citizen to comply with both state and federal requirements or state law obstructs accomplishing and executing Congress' full purposes and objectives. *BIC Pen Corp. v. Carter,* 251 S.W.3d 500, 504 (Tex. 2008) (citations omitted).

Under 42 U.S.C. § 405(h), made applicable to the Medicare Act by 42 U.S.C. § 1395ii, it is clear that section 405(g) "is the sole avenue for judicial review of all 'claims arising under' the Medicare Act." *Heckler,* 466 U.S. at 615. Under 42 U.S.C. § 405(g), a final decision of the Secretary of HHS (issued only after exhaustion of all administrative review) may be reviewed in federal district court. *See Marsaw,* 192 F.Supp.2d at 744. A claim arises under the Medicare Act if it is "'inextricably intertwined' with a Medicare benefits determination," or if "'both the standing and the substantive basis for the presentation' of the claim" is the Medicare Act. *Kaiser v. Blue Cross of Cal.,* 347 F.3d 1107, 1112 (9th Cir. 2003) (quoting *Heckler,* 466 U.S. at 614, 615). Because Edwards's claims are arguably based on state law, we are

concerned only with the first test – whether the claims are inextricably intertwined with a Medicare benefits determination. *Id.*; *see RenCare,* 395 F.3d at 557.

Several federal courts have addressed state law claims very similar to Edwards's and concluded those claims were inextricably intertwined with claims for Medicare reimbursement, and thus arose under the Medicare Act. In *Bodimetric Health Services, Inc. v. Aetna Life & Casualty,* 903 F.2d 480 (7th Cir. 1990), Bodimetric alleged the Secretary released a contractor evaluation critical of Aetna's performance as a Medicare carrier. In response, and in order to improve its contract performance evaluation and retain its contract as a fiscal intermediary, Aetna began denying Bodimetric's applications for reimbursement on a regular basis. *See id.* at 482-83. Bodimetric claimed this "arbitrary campaign of denials" caused it to close its facilities and lose $8 million. *Id.* Bodimetric sued Aetna seeking damages for fraud and other tort and contract causes of action. *Id.* Bodimetric alleged Aetna denied "thousands of claims without regard to their underlying substance" and, like Edwards, asserted "that administrative law judges [had] reversed almost all of Aetna's denials where Bodimetric [had] entered an appearance and argued for reversal." *Id.*[6] The court concluded all of

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[6] The court explained Bodimetric's argument in more detail:

> In the case before us, Bodimetric declares that its state law claims against Aetna are not inextricably

(Continued on following page)

Bodimetric's claims arose under the Medicare Act, stating a "party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits." *Id.* at 487.[7] The court acknowledged the congressional intent behind the Medicare procedures:

> By enacting the exclusive review provisions of the Medicare Act, Congress expressly limited the remedies that can be sought by dissatisfied claimants from fiscal intermediaries. While this may, in some cases, foreclose avenues of relief generally available to civil litigants, it is also the

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> intertwined with a challenge under the Medicare Act to Aetna's denials of individual claims. Essentially, Bodimetric argues that it seeks damages from Aetna's own pocket, not from the Medicare Trust Fund. Moreover, Bodimetric maintains that it cannot raise its challenges to Aetna's unlawful behavior in the administrative hearings provided by the Medicare regulations, and that it does not have other regulatory avenues of relief in which it may pursue its claim.

Bodimetric, 903 F.2d at 484. Edwards makes similar arguments in this case.

[7] *Bodimetric* distinguished between challenges to the amount of benefits, which required administrative exhaustion, and challenges to the regulatory scheme for calculating benefits, which did not. 903 F.2d at 485. That distinction is not longer necessary because the 1986 amendments to the Medicare Act made Part B determinations reviewable to the same extent as Part A determinations. *See U.S. ex rel. Body v. Blue Cross and Blue Shield of Al., Inc.*, 156 F.3d 1098, 1102 n.22 (11th Cir. 1998).

> system Congress clearly intended to implement. Any decision to modify this aspect of the system must be made by Congress, not by the courts.

Id. at 490.

In *Kaiser,* a provider of home health services to Medicare beneficiaries, CHH, substantially reduced the number of its patients and services it provided as a result of pending changes to the rules on allowable costs of home health agencies. 347 F.3d at 1110. However, CHH continued to receive interim payments at relatively high levels based on its prior patient volume. *Id.* As a result, it was overpaid more than a million dollars. CHH sought an extended repayment plan from Blue Cross, but Blue Cross denied the request and decided to withhold all Medicare payments until the overpayment was recouped. Thereafter CHH closed its operations and filed bankruptcy. *Id.* The Kaisers, former shareholders of CHH, obtained from the bankruptcy trustee an assignment of any CHH claims related to Medicare. They then sued Blue Cross and the HCFA[8] under several state and federal laws alleging Blue Cross's conduct forced CHH into bankruptcy, causing CHH's (now the Kaisers') damages. *Id.* at 1111. The Kaisers argued their claims did not arise under Medicare because they sought damages other than

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[8] The Health Care Financing Administration is now known as CMS. *See Marsaw,* 192 F.Supp.2d at 740.

the Medicare payments and noted CHH was pursuing the claim for Medicare payments through the administrative process apart from the Kaisers' claims. *Id.* at 1112 n.2. The ninth circuit concluded "*Bodimetric* is perfectly applicable to the facts in this case" and the Kaisers' claims were "inextricably intertwined" with CHH's claims for Medicare reimbursement. *Id.* at 1114-15 ("Hearing most of the Kaisers' claims would necessarily mean redeciding Blue Cross's CHH-related Medicare decisions."). Even though the Medicare administrative review process would not provide them with the damages they sought, "administrative exhaustion of the Kaisers' claims would still serve the purposes of exhaustion and not be futile in the context of the system." *Id.* at 1115. The court affirmed the district court's dismissal of the suit for failure to exhaust administrative remedies. *Id.*

In both *Bodimetric* and *Kaiser*, the plaintiffs had undertaken the administrative review process with respect to their Medicare reimbursement claims, but had not entirely completed the process. Edwards contends this is a critical distinction from his case because he has completed – and won – the vast majority of the administrative reviews of Blue Cross's denials of his Medicare claims. Thus, despite the obvious similarity between his claims and those in *Bodimetric* and *Kaiser*, Edwards claims he can now sue in state court to recover consequential damages for delays in making those payments.

However, the Fifth Circuit Court of Appeals has concluded that even if an administrative review of the

Medicare reimbursement claims has been completed, state law claims based on the alleged wrongful denial of those claims still "arise under" Medicare and thus were properly dismissed. *Marsaw v. Thompson,* 133 Fed. Appx. 946, 949 (5th Cir. 2005) (not designated for publication). In that case, Marsaw initially sued Trailblazer and the Secretary alleging racial discrimination and various tort and breach of contract claims based on Trailblazer's placing of his clinics "in prepayment review (which forced the clinics to engage in lengthy administrative work to receive Medicare reimbursements) and then denied reimbursements of the submitted claims, ultimately forcing Marsaw out of business." *Id.* at 947.[9] Marsaw's initial suit was dismissed by the district court for his failure to exhaust administrative remedies under the Medicare Act. *See Marsaw,* 192 F.Supp.2d at 737. He did not appeal that decision. *Marsaw,* 133 Fed. Appx. at 947. Instead, after the administrative review of his Medicare claims was completed and he received payment of 98 percent of the claims denied by Trailblazer, Marsaw filed a second suit seeking an additional $50 million in damages from the Secretary and Trailblazer for initially denying his claims. *Marsaw,* 133 Fed. Appx. at 947.

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[9] Edwards made a similar discrimination claim in his sixth amended petition. Marsaw also alleged due process and equal protection violations, breach of contract, tortious interference with contract and prospective business relations, and civil rights violations. *See Marsaw,* 192 F.Supp.2d at 741.

The fifth circuit determined that

> to fully address Marsaw's claim that his constitutional rights were violated through improper enforcement of Medicare regulations, a court would necessarily have to review the propriety of thousands of Trailblazer's Medicare claims determinations and the decisions of its hearing officers to determine whether there was legitimate doubt about Marsaw's compliance.

Id. at 948. The "sole avenue" for judicial review of all claims arising under the Medicare Act is section 405(g) and a "condition for jurisdiction under § 405(g) is that the Medicare system has made a determination adverse to the claimant." *Id.*

We conclude that the trial court would have to review each of Edwards's Medicare reimbursement claims and Blue Cross's decisions to deny them in order to determine if there was a good faith or non-tortious basis for Blue Cross's actions. Even though Edwards has now received an administrative review, he wants to go further and recover amounts in addition to the benefits. To do so, he must prove the original denial was not only incorrect, but was also tortious or a breach of a contractual or statutory duty. However, Medicare only permits a judicial review after exhaustion of administrative reviews and an adverse decision. *Marsaw*, 133 Fed. Appx. at 948. When the administrative review results in payment or a favorable decision for the provider, the statute permits no further review. *Id.* Thus we conclude that,

like Marsaw's claims, Edwards's claims "arise under the Medicare Act (and are not collateral to it) because they are 'inextricably intertwined' with plaintiffs' substantive claims for entitlement under Medicare." *Id.*

Edwards filed a post-submission letter brief arguing *Marsaw* and similar cases are distinguishable because the federal courts concluded only that federal jurisdiction was lacking and did not decide whether state law claims remained for a state court to decide. We are not persuaded by his arguments. While the federal court in *Marsaw* refused to exercise its discretionary supplemental jurisdiction to address the state law claims,[10] the reasoning and analysis of the court's opinion clearly indicates any state law claims were inextricably intertwined with Medicare and thus preempted by the Medicare Act. *See Marsaw*, 133 Fed. Appx. at 948 (addressing Marsaw's claims would require reviewing thousands of the carrier's Medicare claims determinations "to evaluate whether there was legitimate doubt about Marsaw's compliance").[11]

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[10] *See Marsaw*, 133 Fed. Appx. at 949 ("In light of the above, Marsaw has shown no error with regard to the dismissal of his supplemental state law claims.").

[11] The court also concluded the carrier, Trialblazer, qualified for sovereign immunity "because it was acting under the direction of the federal government in performing duties delegated by HHS." *Marsaw*, 133 Fed. Appx. at 949. Marsaw's claims arose from Trailblazer's decisions to pay or deny reimbursements; actions within the scope of its official duties

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Edwards argues his claims do not arise under the Medicare act because he is not seeking to recover Medicare benefits, but "foreseeable consequential damages he incurred when he was forced to close his medical practice as a proximate result of Blue Cross' [sic] conduct in denying him any revenue for a period of two years." However, a suit seeking non-Medicare damages may still arise under the Medicare Act. *See Marin v. HEW, Health Care Fin. Agency,* 769 F.2d 590, 592 (9th Cir. 1985) (noting provider's suit for damages caused by negligent failure to process claims was "anticipated by the statute" and provider's "demand for greater damages than the statute provides would render meaningless the jurisdiction restriction of § 405(h)"). *Bodimetric* also recognized that congress has limited the remedies available for dissatisfied providers. *Bodimetric,* 903 F.2d at 487 n.5 (observing administrative process may not afford plaintiff all relief it sought pursuant to its state law claims, but "Congress, through its establishment of a limited review process, has provided the remedies it deems necessary to effectuate the Medicare claims process"). As the ninth circuit recognized, "The fact that the Kaisers seek damages beyond the reimbursement payments available under Medicare does not exclude the possibility that their case arises under Medicare. Simply put, the type of remedy

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and entitling Trailblazer to "the same official immunity as officers or employees of the United States performing discretionary duties." *Id.*

sought is not strongly probative of whether a claim falls under § 405(h)." *Kaiser*, 347 F.3d at 1112; *see also Marsaw*, 133 Fed. Appx. at 948.

Edwards argues not all state law tort claims relating to Medicare benefits are preempted by the Medicare Act. *See Ardary v. Aetna Health Plans of S. Cal.*, 98 F.3d 496 (9th Cir. 1996); *Kelly v. Advantage Health, Inc.*, 1999 WL 294796 (E.D. La. May 11, 1999) (not designated for publication). Those and similar cases, however, are distinguishable as they involved claims by the Medicare beneficiary or their representatives for wrongful death or damages for state law torts for delays in granting the benefits.[12] These cases are not persuasive in light of other cases more closely on point. Indeed, in *Kaiser*, a case very similar to Edwards's, the ninth circuit expressly limited its holding in *Ardary* to patient tort claims. *Kaiser*, 347 F.3d at 1114 ("the *Ardary* analysis convinces us that its holding does not extend beyond patients and torts committed in the sale or provision of medical services").[13]

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[12] In *Ardary*, the survivors of a Medicare beneficiary brought state law wrongful death claims against the Medicare carrier based on its refusal, despite prior representations, to authorize airlift transportation for the beneficiary from a remote area following a heart attack. *Ardary*, 98 F.3d at 496-98. *Kelly* involved claims brought by the Medicare beneficiary against his Medicare HMO for delays in authorizing in-patient treatment. *Kelly*, 1999 WL 294796 at *1-2.

[13] We also distinguish cases involving Medicare Part C, an HMO program, because of the differences between the fixed

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Like other courts, we are "persuaded by *Bodimetric* and subsequent cases holding that claims for consequential damages resulting from adverse decisions by Medicare carriers are 'inextricably intertwined' with claims for benefits." *Reg'l Med. Transp., Inc. v. Highmark, Inc.*, 541 F.Supp.2d 718, 729 (E.D. Pa. 2008). Edwards's claims are based on Blue Cross's alleged wrongdoing in the course of reviewing and administering his Medicare reimbursement claims. Edwards alleges most of those

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payment HMO system and the provider reimbursement programs of Medicare Part A and Part B. *See RenCare*, 395 F.3d at 556-57, 558-59 (discussing characteristics of Medicare Part C and distinguishing Part A and B cases because of the financial risk borne by the administering entity under Part C); *Christus Health Gulf Coast v. Aetna, Inc.*, 237 S.W.3d 338, 339-40, 343 (Tex. 2007) (discussing features of Medicare Part C or Medicare Advantage program; and stating "it is unclear whether *Heckler*'s 'arising under' test even applies to Medicare Advantage [Part C] claims."). It is undisputed that all of Edwards's allegations arise out of his status as a Medicare Part B provider and Blue Cross's role as a Medicare Part B carrier.

RenCare, Ltd. v. U. Med. Resources, Inc., 180 S.W.3d 160 (Tex. App. – San Antonio 2005, no pet.) is also distinguishable. In that case, a health care provider sued the patient's private health insurance plan to recover payment for services rendered to the patient based on plan's representation it had primary coverage for the services. *Id.* at 163. The plan later denied coverage and, after suit was filed, argued Medicare Part B was the primary payer for the services. *Id.* The Medicare carrier, Trailblazer Health Enterprises, denied coverage because the insurance plan was primary. *Id.* at 164. The suit did not arise under the Medicare Act because it was a suit between two private entities over coverage under a private health insurance plan. *Id.* at 169-70.

reimbursement claims have been paid after administrative review, but "[t]o the extent that plaintiffs have obtained the relief sought in those proceedings, plaintiffs are limited to that recovery and cannot obtain more than permitted by the Medicare program by couching their claims as state law challenges." *Id.* "[I]rrespective of what relief plaintiffs actually obtained in the administrative process, [42 U.S.C.] § 405(h) bars judicial review of plaintiffs' state law tort claims, all of which are 'inextricably intertwined' with claims for Medicare benefits." *Id.* Because Edwards has now exhausted his administrative remedies and obtained "precisely the Medicare payments he claims were wrongfully denied, and the statute entitles him to no other relief, his case is moot." *Marsaw,* 133 Fed. Appx. at 948.

CONCLUSION

We conclude Edwards's pleading and the record establish his claims are preempted as a matter of law and this impediment to his suit cannot be corrected by amending his pleadings.[14] Because this ground is sufficient to support the trial court's summary judgment, we need not address the remaining sub-issues

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[14] Although Edwards argues his suit should not be dismissed without the opportunity to amend, he did amend his petition in response to the motion for summary judgment and fails to explain how he can amend his pleading to avoid preemption of his claims.

raised in Edwards's appeal. TEX. R. APP. P. 47.1. We overrule Edwards's sole issue on appeal.

We affirm the trial court's judgment.

/s/ J Moseley
JIM MOSELEY
JUSTICE

071281F.P05

CAUSE NO. 03-06872-B

DRALVES GENE EDWARDS, M.D.,	§	**IN THE DISTRICT COURT OF**
PLAINTIFF,	§	
vs.	§	**DALLAS COUNTY, TEXAS**
BLUE CROSS BLUE SHIELD OF TEXAS, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY and BLUE CROSS BLUE SHIELD ASSOCIATION,	§	
DEFENDANTS.	§	**44TH JUDICIAL DISTRICT**

ORDER ON BLUE CROSS BLUE SHIELD OF TEXAS'S MOTION FOR SUMMARY JUDGMENT AND BRIEF IN SUPPORT

The Court, having considered Blue Cross Blue Shield of Texas's Motion for Summary Judgment and Brief in Support thereof (the "Motion"), the response, if any, and the summary judgment record on file, finds that the Motion is well taken and should be and hereby is GRANTED.

It is, therefore, ORDERED, Blue Cross Blue Shield of Texas's Motion for Summary Judgment and Brief in Support thereof is GRANTED.

It is so ORDERED on this the 26th day of June, 2007.

/s/ Carlos R. Cortez
Judge Presiding

(Supreme Court of Texas Orders 06/26/2009)

THE FOLLOWING PETITIONS FOR REVIEW ARE DENIED:

09-0209 DRALVES GENE EDWARDS, M.D. v. BLUE CROSS BLUE SHIELD OF TEXAS, A DIVISION OF HEALTH CARE SERVICE CORP.; from Dallas County; 5th district (05-07-01281-CV, ___ SW3d ___, 12-19-08)

Supreme Court, U.S.
FILED
NOV 30 2009
OFFICE OF THE CLERK

No. 09-364

IN THE

Supreme Court of the United States

DRALVES GENE EDWARDS,

Petitioner,

v.

BLUE CROSS BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORPORATION,
A MUTUAL LEGAL RESERVE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
COURT OF APPEALS OF TEXAS, FIFTH DISTRICT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Respondent objects to the format of the "Question Presented" by the Petitioner. The question was presented by Petitioner as:

> Whether the Texas Court of Appeals wrongly concluded (contrary to the decisions from other federal and state courts of appeals) that all state law claims for consequential damages against Medicare fiscal intermediaries are preempted under the Medicare Act.

The Texas Court of Appeals did not conclude that all state law claims for consequential damages against a Medicare fiscal intermediary are preempted under the Medicare Act. Pet'r's. App. 20. The Texas Court of Appeals specifically distinguished cases where state law claims were permitted to proceed against Medicare fiscal intermediaries for wrongful death or damages for state law torts for delays in granting the benefits. *Id.* As discussed in the body of this brief, the Texas Court of Appeals held that the claims brought by the Petitioner, as a Medicare provider seeking consequential damages for denial of benefits, were preempted as a matter of law. *Id.* at 22.

Respondent would respectfully submit to the Court that the proper question presented is:

> Whether the Texas Court of Appeals properly concluded (in accordance with decisions from other federal and state courts of appeals) that Petitioner's state laws claims for alleged consequential damages against a Medicare fiscal intermediary are preempted under the Medicare Act.

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

TABLE OF CONTENTS ii

TABLE OF CITED AUTHORITIES v

BACKGROUND AND INTRODUCTION 1

MISSTATEMENTS AND INACCURACIES IN THE PETITION 2

A. Petitioner has Inaccurately Described the Nature of the Prepayment Review. 2

B. Petitioner Attempts to Characterize his Medicare Claims as Claims for Breach of Contract. 3

C. Petitioner's Description of the Procedural History of this Case is Inaccurate and Misleading. 3

D. If Taken as True, Petitioner's Concession that He has Concluded the Administrative Appeals Process Renders any Further Review Moot. 4

Contents

	Page
ARGUMENT AND AUTHORITIES	5
I. THE COURT OF APPEALS HOLDING THAT PETITIONER'S CLAIMS WERE INEXTRICABLY INTERTWINED WITH CLAIMS FOR MEDICARE BENEFITS SHOULD BE AFFIRMED.	5
A. Petitioner Brought His Claims for Damages in the Wrong Court and Against the Wrong Defendant.	5
1. The Relevant Medicare Statutory Background.	6
2. The Role of the Medicare Contractor.	7
3. Administrative and Judicial Review of Benefit Determinations.	8
B. Petitioner's Claims Arise Under the Medicare Act.	11
1. Conduct Alleged by Petitioner Giving Rise to His Claims.	11

Contents

Page

2. Contrary to Petitioner's Assertions, there is No Split Amongst the Circuits Concerning the Review of Medicare Benefit Determinations. 16

3. The Administrative Appeals Process is Petitioner's Sole Remedy. 19

II. PETITIONER ASKS THE COURT TO CREATE A NEW TOLLING THEORY UNSUPPORTED BY ANY LAW. 21

CONCLUSION AND PRAYER 24

TABLE OF CITED AUTHORITIES

Page

FEDERAL COURT CASES

Affiliated Prof'l Home Health Care Agency v. Shalala,
164 F.3d 282 (5th Cir. 1999) 10, 12, 14

Ardary v. Aetna Health Plans of Southern Cal.,
98 F.3d 496 (9th Cir. 1996) 16, 17, 18

Bodimetric Health Servs.,
903 F.2d 480 (7th Cir. 1990) ..... *passim*

Heckler v. Ringer,
466 U.S. 602 (1984) 5, 8-9

Hofler v. Aetna U.S. Healthcare of Cal., Inc.,
296 F.3d 764 (9th Cir. 2002) 16-17

Hooker v. U.S. Dep't of Health and Human Servs.,
858 F.2d 525 (9th Cir. 1988) 20

Kaiser v. Blue Cross of Cal.,
347 F.3d 1107 (9th Cir. 2003) 13, 15, 17, 18

Kelly v. Advantage Health, Inc.,
1999 WL 294796 (E.D. La. 1999) 18

Kennedy v. Health Options, Inc.,
329 F. Supp. 2d 1314 (S.D. Fla. 2004) 17

Cited Authorities

Page

Marin v. HEW, Health Care Fin. Agency,
769 F.2d 590 (9th Cir.1985) 13

Marsaw v. Blue Cross-Blue Shield of Tex. Health Enters., L.L.C.,
192 F.Supp.2d 737 (S.D. Tex. 2002) 13, 19

Marsaw v. Thompson,
133 Fed Appx. 946, 2005 WL 1170445
(5th Cir. 2005) 19, 20

Midland Psychiatric Assocs. v. United States,
145 F.3d 1000 (8th Cir. 1998) 13, 15

Plocica v. Nylcare, Inc.,
43 F. Supp. 2d 658 (N.D. Tex. 1999) 17

Schweiker v. Chilicky,
487 U.S. 412 (1988) 20

Shalala v. Ill. Council on Long Term Care, Inc.,
529 U.S. 1 (2000) 5, 8, 11

United States v. Blue Cross & Blue Shield of Ala., Inc.,
156 F.3d 1098 (11th Cir.1998) 14

Wartenberg v. Aetna U.S. Healthcare, Inc.,
2 F. Supp. 2d 273 (E.D.N.Y. 1998) 17

Weinberger v. Salfi,
422 U.S. 749 (1975) 10

Cited Authorities

Page

FEDERAL STATUTES

42 U.S.C. § 405(g) ..... *passim*

42 U.S.C. § 405(h) ..... *passim*

42 U.S.C. § 1395d 6

42 U.S.C. § 1395f 7

42 U.S.C. § 1395g(a) 7

42 U.S.C. § 1395k(a) 6

42 U.S.C. § 1395u(b)(3) 7

42 U.S.C. § 1395y(a) 7

42 U.S.C. § 1395cc(a) 7

42 U.S.C. § 1395ff 5

42 U.S.C. § 1395ii 5

REGULATIONS

20 C.F.R. § 404.981 9

20 C.F.R. § 422.210(a) 9

20 C.F.R. § 422.210(c) 9

Cited Authorities

	Page
20 C.F.R. § 422.210(d)	9
20 C.F.R. § 481	9
42 C.F.R. § 405.501	7
42 C.F.R. § 405.803	8
42 C.F.R. § 405.807	8
42 C.F.R. § 405.815	8
42 C.F.R. § 405.821	8
42 C.F.R. § 405.855	8
42 C.F.R. § 405.856	8
42 C.F.R. § 405.857	9
42 C.F.R. § 410.20	6
42 C.F.R. § 410.60	6
42 C.F.R. § 410.200	7
42 C.F.R. § 421	7
42 C.F.R. § 421.5	7
42 C.F.R. § 421.200(a)	7
42 C.F.R. § 421.200(e)	7

BACKGROUND AND INTRODUCTION

Petitioner is a Texas physician who chose to treat patients covered by Medicare. By doing so, he was required to comply with the rules and regulations of Medicare. Not satisfied with the recovery he alleges to have received from Medicare, he set forth to get a little extra for his efforts from the Respondent, a fiscal intermediary for the Medicare system. Petitioner now finds his case entangled in a web of deceit of his own making. The Petition for Writ is full of misrepresentations and misstatements of fact and law. His Writ tries to ensnare this court in his web to overcome the prior decisions of the trial court, the court of appeals, and the Texas Supreme Court.

The underlying factual basis of the Petitioner's lawsuit was the handling of Medicare claims. When faced with the exclusive remedy provided by Medicare to a physician who appeals the denial of a claim, he added state law claims and tried to distance his case from his new remedies. Petitioner was then faced with a limitations bar and so he created a new theory of law: that his state law claims were tolled while appealing his Medicare claims. This reliance on Medicare to provide a lifeline to his dead claims created the intertwined allegations which have been presented to the Court.

The Petitioner's Writ stands as an excellent example of his state law claims being inextricably intertwined with his Medicare claims. Ultimately, all of his state law complaints require an evaluation of some underlying Medicare claim to determine any basis for the claim. Inherent in such an analysis is a determination of what

should have been done with the Medicare claim. Once down this path, it is impossible not to have courts improperly rendering opinions on how Medicare claims should be handled. As described below, the current system is specifically designed to avoid such confusion.

MISSTATEMENTS AND INACCURACIES IN THE PETITION

Pursuant to Rule 15(2) of the Rules of the Supreme Court of the United States, Respondent would respectfully submit to this court that Petitioner has made a number of factual and legal misstatements in his Petition. Respondent hereby addresses these issues as they bear on what issues would properly be before the Court if certiorari were to be granted.

A. Petitioner has Inaccurately Described the Nature of the Prepayment Review.

On page six of his Petition, Petitioner states that "[a]lthough medical necessities are covered under Medicare, Blue Cross categorically denied medical conditions such as breast cancer, congestive heart failure, and diabetes." Petitioner's statement is misleading as Respondent did not deny or place any "medical conditions" under prepayment review. Instead, the services provided by Petitioner were placed under a prepayment review to determine the medical necessity of the treatment. Similarly, Petitioner notes on page seven of his Petition that "two independent board certified Internal Medicare Specialists reviewed Dr. Edwards' claims and concluded that all medical

conditions were covered under Medicare and should have been paid." Again, Petitioner confuses the purpose and scope of the prepayment review. A medical condition itself is not the issue. The prepayment review of claims by the Petitioner to Medicare was, on all of the claims he seeks, the real issue.

B. Petitioner Attempts to Characterize his Medicare Claims as Claims for Breach of Contract.

Petitioner attempts to recast the nature of his Medicare claims on page nine of his Petition. Petitioner states that "Edwards' complaint did not, however, request damages for an illegal denial of Medicare payments, it raised only state law breach of contract claims." The problem remains that in more than a decade of litigation, he has failed to identify any damage for breach of contract that is not an alleged failure to pay a Medicare claim. The basis of all of Petitioner's claims was his allegation that Respondent improperly denied his claims for Medicare benefits.

C. Petitioner's Description of the Procedural History of this Case is Inaccurate and Misleading.

In a further attempt to disguise the nature of his claims, Petitioner misrepresents the procedural history of this dispute at the trial court level. On page nine of his Petition, Petitioner states "the case filed against Blue Cross and Blue Shield of Texas – and not the Government, its employees or officers – was removed to federal court in 2005. The federal court remanded

the case, finding lack of diversity or federal question jurisdiction." This statement is too simple a statement of the procedural history of this matter and is misleading. After bringing suit against Respondent, Petitioner subsequently added Trailblazer, another insurance company, as a defendant. Trailblazer then removed the case to federal court. Petitioner then dismissed his claims against Trailblazer. During the removal by Trailblazer, Respondent did not make a showing of an exclusive federal issue. Therefore, the district court then remanded the case to state court but noted that Respondent could still raise its federal defenses, which it has throughout the course of this litigation.

D. If Taken as True, Petitioner's Concession that He has Concluded the Administrative Appeals Process Renders any Further Review Moot.

Petitioner concedes that he has received the very benefits he alleges were denied to him by Respondent. On page eighteen, in discussing the review process, Petitioner notes that "the review the court of appeals decried was already conducted successfully through the administrative review process." In addition, on page nineteen of his Petition, he notes that "Edwards has already received benefits through the exhaustive administrative appeals." As discussed below, these statements, if taken as true, foreclose any further consideration of any of the Medicare claims that form the basis of Petitioner's lawsuit.

ARGUMENT AND AUTHORITIES

I. THE COURT OF APPEALS HOLDING THAT PETITIONER'S CLAIMS WERE INEXTRICABLY INTERTWINED WITH CLAIMS FOR MEDICARE BENEFITS SHOULD BE AFFIRMED.

A. Petitioner Brought His Claims for Damages in the Wrong Court and Against the Wrong Defendant.

Petitioner's lawsuit for the alleged tort claims is in direct contradiction to the exclusive nature of Medicare Act's judicial review provisions. It is well-settled that, "[t]he third sentence of 42 U.S.C. § 405(h), made applicable to the Medicare Act by 42 U.S.C. § 1395ii, provides that § 405(g) . . . is the sole avenue for judicial review for all 'claim[s] arising under' the Medicare Act." *See Shalala v. Ill. Council on Long Term Care, Inc.* 529 U.S. 1, 35 (2000), quoting, *Heckler*, 466 U.S. 602, 614-615 (1984). As discussed below, Petitioner's lawsuit sought the wrong relief, against the wrong party, in the wrong court.[1]

[1] If Petitioner was dissatisfied with the final decision of the Secretary of Health and Human Services, he should have filed an action against the Secretary in federal district court seeking reversal of the denied claims, as expressly set forth in 42 U.S.C. §§ 405(g), (h). If Petitioner was seeking remedies not set forth in that limited judicial review, then Petitioner's remedies and claims are preempted by the Supremacy clause and the very terms of the statute itself.

1. *The Relevant Medicare Statutory Background.*

The Medicare program, established by Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.*, assists elderly and disabled persons in the purchase of necessary health care. The Centers for Medicare and Medicaid Services ("CMS") is the component of the United States Department of Health and Human Services ("DHHS") which administers the Medicare program. The program is divided into two primary parts: one program is called "Hospital Insurance Benefits for the Aged and Disabled" (or Medicare Part A) and the other program is the "Supplementary Medical Insurance Benefits for the Aged and Disabled" (or Medicare Part B). Medicare Part A pays for inpatient hospital stays, skilled nursing care, hospice and certain home health services.[2] Medicare Part B provides for outpatient physical therapy, occupational therapy, speech pathology, doctors' services, diagnostic tests, ambulatory services, durable medical equipment, mental health services, clinical laboratory services, limited home health care, outpatient hospital services and blood provided on an outpatient basis.[3] At issue in this case are Medicare Part B benefits which include payment for doctors' services.[4]

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[2] *See* 42 U.S.C. §1395d.

[3] 42 U.S.C. §1395k(a); 42 C.F.R. § 410.60.

[4] 42 C.F.R. § 410.20.

2. *The Role of the Medicare Contractor.*

The Secretary is authorized to contract with private insurance companies to handle the administrative details of Part B reimbursements.[5] Medicare carrier contracts are not conventional Government contracts. The carrier is not permitted to earn profit on the contract, and the carrier's costs are passed directly to the Government. The carrier is bound by the Medicare statute, the regulations, and the guidelines issued by CMS. Under the Medicare statute, a contractor may make payments only to a holder of a valid Medicare provider agreement.[6] Medicare providers' claims for payment are sent to the carrier for processing and payment.[7] The carrier reviews the claim and pays benefits according to detailed, pre-established procedures set out in the Medicare Act.[8] The carrier must ensure that payment is made only for services that are furnished to Medicare beneficiaries and covered under the Medicare program, and must deny payment for services which are not reasonable or medically necessary.[9] Payments to the provider are made out of the Medicare Trust Fund; the carrier has no vested interest in the Medicare fund. The carrier is also required to conduct audits of the records of providers, as necessary, to assure that payments are made properly.[10]

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[5] 42 C.F.R. § 421.5; *See generally,* 42 C.F.R. § 421.200, *et seq.*

[6] *See* 42 U.S.C. §§ 1395f, 1395g(a), and 1395cc(a).

[7] *See* 42 C.F.R. Part 421.

[8] 42 U.S.C. §§ 1395u(b)(3), 1395y(a), the CMS regulations, see 42 C.F.R. §§ 405.501 *et seq.*, 421.200, and other instructions issued by CMS.

[9] 42 C.F.R. §421.200(a).

[10] 42 C.F.R. §421.200(e).

3. *Administrative and Judicial Review of Benefit Determinations.*

Congress has provided for an elaborate and exclusive review process to be used by parties dissatisfied with the initial disposition of their Medicare claims.[11] The Medicare carrier makes an initial determination when a request for payment for Part B benefits is submitted and may also review determinations after payment has been made.[12] If a provider of medical services is dissatisfied with the initial determination, it may request a review of the claim.[13] Following the carrier's review determination, the provider may obtain a carrier hearing if the amount remaining in controversy is at least $100.[14] If the provider is dissatisfied with the hearing officer's decision, it may request a hearing before an administrative law judge ("ALJ").[15] If a provider is dissatisfied with the ALJ's decision or with the dismissal of a hearing request, it may request that the Departmental Appeals Board, Medicare Appeals Council, review that action.[16] The Medicare Appeals Council may deny or dismiss the request for review, or it may grant the request and either issue a decision or

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[11] 42 U.S.C. §§ 405 (g) & (h), 1395ff.

[12] 42 C.F.R. §405.803; 42 U.S.C. §1395ff.

[13] 42 C.F.R. §405.807

[14] 42 C.F.R. §§405.815 and 405.821

[15] 42 C.F.R. §§405.815 and 405.855.

[16] 42 C.F.R. §405.856 (The Medicare Appeals Council ("MAC")is part of the Departmental Appeal Board of DHHS)

remand the case to an ALJ.[17] Administrative exhaustion is attained when the provider seeks and receives a determination from the Medicare Appeals Council.[18] Thus, a provider may obtain judicial review of a decision by an ALJ if the Medicare Appeals Council has denied the provider's request for review, or if the Medicare Appeals Council issues the final decision of the Secretary.[19] Any civil action for judicial review must be instituted within 60 days after the Medicare Appeals Council's notice of denial of request for review of the ALJ's decision or notice of the decision by the Medicare Appeals Council is received.[20] Where any civil action for judicial review is instituted, the Secretary of the Department of Health and Human Services, in his or her official capacity, is the only proper defendant.[21]

A well-recognized line of United States Supreme Court cases establish that jurisdiction under the Medicare Act to review decisions of the Secretary is limited to that provided for in 42 U.S.C. § 405(g) by the language of § 405(h). These cases establish that Medicare reimbursement disputes must be addressed solely in accordance with the dictates of 42 U.S.C. § 405(g). *See Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 120 S.Ct. 1084, 146 L.Ed.2d 1 (2000); *Heckler v. Ringer*, 466 U.S. 602, 605, 104 S.Ct. 2013, 80 L.Ed.2d

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[17] 20 C.F.R. §481.

[18] 42 C.F.R. § 405.857; 20 C.F.R. § 422.210(a).

[19] 42 C.F.R. § 405.857.

[20] 20 C.F.R. § 404.981; 20 C.F.R. § 422.210(c)

[21] 42 U.S.C. § 405(g); 20 C.F.R. § 422.210(d).

622 (1984); *Weinberger v. Salfi*, 422 U.S. 749, 760-61 (1975); *Affiliated Professional Home Health Care Agency v. Shalala*, 164 F.3d 282 (5th Cir. 1999).

The plain language of § 405(h), as incorporated by 42 U.S.C. § 1395ii, expressly limits the review of claims that "arise under" the Medicare Act:

> The findings and decision of the Secretary after such a hearing shall be binding upon all individuals who were parties to such a hearing. *No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided.* No action against the United States, the Secretary, or any officer or employee shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

(emphasis added).

The Medicare Act simply does not allow judicial review of the Secretary's decisions by the state courts. 42 U.S.C. § 405(g) states, in relevant part:

> Any individual, after any final decision of the [Secretary] made after a hearing to which he was a party, . . . may obtain a review of such decision by a civil action. . . . Such action *shall be brought in the district court of the United States*. . . . The court shall have power to enter . . . a judgment affirming, modifying, or reversing the decision of the [Secretary]....

> The findings of the [Secretary] as to any fact, if supported by substantial evidence, shall be conclusive. . . .

(emphasis added).

Thus, any claim "arising under" the Medicare Act must be brought through the exclusive judicial review provision of the Medicare Act, 42 U.S.C. § 405(g), regardless of whether it is denominated as procedural or constitutional. *See Ill. Council*, 120 S.Ct. at 1094. The statute does not provide for review in state court jury trials.

B. Petitioner's Claims Arise Under the Medicare Act.

The Dallas Court of Appeals correctly held that Petitioner's claims against Blue Cross Blue Shield of Texas were properly dismissed since jurisdiction to review claims "arising under" the Medicare Act against carriers acting on behalf of the Secretary, is limited to that allowed by 42 U.S.C. §§ 405(g) and (h). At bottom, Petitioner was claiming that Medicare should have paid for his services.

1. *Conduct Alleged by Petitioner Giving Rise to His Claims.*

Dr. Edward's claims are predicated on the determination of Medicare benefits. As a result of Respondent's denial of Medicare claims payment, Petitioner alleged that "Defendants owe money to Dr. Edwards for services rendered to his patients" and

sought damages for breach of contract, fraud, gross negligence, tortious interference with Petitioner's relationship with his patients and with his prospective relationship with future patients, abuse of process, libel, slander, unjust enrichment and damages under the Texas Medical Liability Act.

It was clear to the court of appeals that the basis of Petitioner's dispute with Respondent was the review and denial of Medicare benefits and attempts to recover special damages. Petitioner's state court claims clearly "arose under" the Medicare Act. Petitioner alleges that Respondent denied almost one-hundred percent (100%) of all Medicare claims submitted for payment stating that the claims were for non-covered services and/or were not medically necessary. Pet'r's. Br. p. 8. The court of appeals correctly concluded that "the trial court would have to review each of Edwards's Medicare reimbursement claims and Blue Cross's decision to deny them in order to determine if there was a good faith or non-tortious basis for Blue Cross's actions." Pet'r's. App. 17. Therefore, the court of appeals concluded that Edwards's claims "[arose] under the Medicare Act (and are not collateral to it) because they are 'inextricably intertwined' with [Petitioner's] substantive claims for entitlement under Medicare." Pet'r's. App. 18.

Furthermore, every cause of action expressly or implicitly raised by Petitioner's Petition has been found by other courts in other cases to "arise under" the Medicare Act:

- *Affiliated Professional Home Health Care Agency v. Shalala*, 164 F.3d 282, 285 (5th Cir. 1999)(due process and equal protection);

- *Bodimetric Health Servs. v. Aetna Life & Cas.*, 903 F.2d 480 (7th Cir. 1990); *Midland Psychiatric Associates v. United States*, 145 F.3d 1000, 1003 (8th Cir. 1998)(state law tort claims);

- *Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107 (9th Cir. 2003)(contractual claims, constitutional claims, defamation, other business torts);

- *See Marin v. HEW, Health Care Fin. Agency*, 769 F.2d 590, 592 (9th Cir.1985) (noting, in a home health service provider's suit against the government "for damages caused by negligent failure to process" claims, that "[t]he substantive cause of action [was] anticipated by the statute" and that the plaintiff's "demand for greater damages than the statute provides would render meaningless the jurisdiction restriction of § 405(h)"); and

- *Marsaw v. Blue Cross-Blue Shield of Tex. Health Enters., L.L.C.*, 192 F. Supp. 2d 737, 744 (S.D. Tex. 2002) (contractual claims, constitutional claims, business torts).

Moreover, courts, both state and federal, have considered numerous cases that do not, on their face, appear to claim specific Medicare benefits or reimbursements yet have been found to arise under the Medicare Act. One category of such cases are those cases

that are "[c]leverly concealed claims for benefits." *United States v. Blue Cross & Blue Shield of Ala., Inc.*, 156 F.3d 1098, 1109 (11th Cir.1998).

In the *Affiliated Professional* ("APRO") case, the Fifth Circuit explained that:

> . . . to fully address [a provider's] claim that their due process and equal protection rights were violated through the improper enforcement of Medicare regulations, a court would necessarily have to immerse itself in those regulations and make a factual determination as to whether [the provider] was actually in compliance. Given the administrative nature of that inquiry, it cannot be reasonably concluded that [the provider's] claim is collateral to a claim for administrative entitlement.

164 F.3d at 285. Likewise, a trial court in the instant case reviewing Petitioner's claims would necessarily have to immerse itself in Medicare regulations and make a factual determination as to whether Petitioner's claims for payment were payable under the Medicare program. This judicial review is reserved to the federal district courts by the express language of 42 U.S.C. §405(g).

In *Bodimetric*, a provider sued the Medicare contractor for damages, fraud, negligent misrepresentation, breach of contract, tortious breach of implied covenant of good faith and fair dealing, and other tort claims. However, the court noted that the

claim was that they should be paid for their services. *Id.* at 484. The *Bodimetric* court held:

> A party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits. If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined.

Bodimetric, 903 F.2d at 487 (citations omitted). The court found that the plaintiff's claims against the Medicare contractor arose under the Medicare Act and that the plaintiff could not circumvent the terms of section 405(h) simply because a private entity serves a public function. *Id.* at 488. "A claim may arise under the Medicare Act even though, as pleaded, it also arises under some other law." *Midland*, 145 F.3d at 1004. "A claim does arise under the Medicare Act if it is 'inextricably intertwined' with a Medicare benefits determination." *Id.*

In *Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107 (9th Cir. 2003), the owners and operators of a Medicare provider sued the Medicare fiscal intermediary alleging violation of the Fifth Amendment, defamation, invasion of privacy, and breach of contract. The court held that the fact that the plaintiffs sought damages beyond reimbursement payments available under Medicare to

the provider did not exclude the possibility that suit arose under the Medicare Act so as to require exhaustion of administrative remedies prior to judicial review pursuant to 42 U.S.C. §405(g) and (h). Similarly, Petitioner's claims are inextricably intertwined with a Medicare benefits determinations and, as such, "arise under" the Medicare Act.

2. *Contrary to Petitioner's Assertions, there is No Split Amongst the Circuits Concerning the Review of Medicare Benefit Determinations.*

Petitioner relies on a series of cases which he claims stand for the proposition that "courts have held that state law claims against a Medicare carrier or fiscal intermediary, such as Blue Cross, are not pre-empted by the Medicare Act." Pet'r's. Br. p. 14. Petitioner improperly relies on these cases in order to create the appearance of a split amongst the circuits concerning the exclusive provisions of the Medicare Act. However, the circuits themselves have eliminated any perceived split.

The cases cited by Petitioner are the progeny of the Ninth Circuit Court of Appeal's decision in *Ardary v. Aetna Health Plans of Southern Cal.*, 98 F.3d 496 (9th Cir. 1996). In those decisions, the courts determined that wrongful death and other state law claims stemming from the failure to provide medical services (not the failure to pay claims) were not inextricably intertwined with a claim for Medicare benefits, and therefore, they did not arise under the Medicare Act. *See, e.g., Hofler v. Aetna US Healthcare of Cal., Inc.*, 296 F.3d 764, 769-

70 (9th Cir. 2002); *also see Kennedy v. Health Options, Inc.*, 329 F. Supp. 2d 1314, 1315-17 (S.D. Fla. 2004); *Plocica v. Nylcare of Tex., Inc.*, 43 F. Supp. 2d 658, 660-663 (N.D. Tex. 1999); *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273, 277-78 (E.D.N.Y. 1998).

The Ninth Circuit Court of Appeals explicitly limited its own holding in *Ardary* in a subsequent decision. The Ninth Circuit was considering a case where the plaintiff was a health care provider that allegedly was forced into bankruptcy after a Medicare fiscal intermediary began recouping overpayments from Medicare reimbursement checks. *Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107, 1109-10 (9th Cir. 2003). The court stated, "Simply put, the type or remedy sought is not strongly probative of whether a claim falls under § 405(h)." *Id.* at 1112. The court stated that: "[i]ndeed, the *Ardary* analysis convinces us that its holding does not extend beyond patients and torts committed in the sale and provision of medical services." *Id.* at 1113 (emphasis added). Furthermore, the Ninth Circuit found that *Bodimetric* was applicable to the facts of the case, and that the plaintiff's claims for damages was "inextricably intertwined" with a claims for Medicare reimbursement that would require redeciding Medicare decisions, and therefore, the administrative appeals process was applicable. *Id.* at 1114.

Petitioner also attempts to support his claim of a circuit split by erroneously relying on a decision from the Eastern District of Louisiana in support of his claim that his state law tort claims do not arise under the Medicare Act (*i.e.*, are not inextricably intertwined with

a claim for benefits). Pet'r's. Br. p. 15-16. In *Kelly v. Advantage Health, Inc.*, 1999 WL 294796 (E.D. La. 1999) (not designated for publication), the district court considered the plaintiff's motion to remand their suit alleging state law claims against a Medicare provider. *Id.* at *1. Citing *Ardary*, the court determined that an award of benefits would not cure the plaintiff's injuries, which resulted from a delay in providing medical services and not from the denial of benefits. *Id.* at *2. The court distinguished *Bodimetric* and determined there was no underlying claim for benefits. *Id.*

As the court of appeals recognized, the present dispute is clearly distinguishable from *Ardary* and *Kelly*. In this case, Petitioner *is not a patient* seeking damages for the *denial of medical services*. Petitioner did not bring suit against BCBSTX for wrongful death or damages for state law torts for delays in granting medical benefits. Pet'r's. App. p. 20. Petitioner is seeking damages related to the denial of benefits for medical services rendered to patients. As *Bodimetric* and *Kaiser* have shown, Petitioner's causes of action are based on a claim for benefits. Therefore, these claims are inextricably intertwined with a claim for Medicare reimbursement and limited to the remedies available through the administrative appeals process. *Bodimetric* and *Kaiser* are on point, while *Ardary* and its progeny are inapplicable.

Simply put, there is no circuit split. Petitioner's claim of a circuit split is a self-serving attempt to revive his preempted claims and ignores clear precedent. The alleged split described by Petitioner is merely a fiction, and an opinion from this Court will not serve to resolve any dispute amongst the circuits as there is nothing to resolve.

3. *The Administrative Appeals Process is Petitioner's Sole Remedy.*

Congress devised an elaborate and exclusive remedial scheme for providers, such as Petitioner, dissatisfied with the initial payment determination by the carrier. *See* 42 U.S.C. §§ 405(g) and (h). Specifically, a dissatisfied provider, such as Petitioner, may avail himself of the administrative process, at the end of which, either the carrier pays the provider or the provider may seek judicial review of the resulting final agency decision. If the district court ultimately rules in the provider's favor, the remedy is simply payment for claims submitted. Even though a provider may never be able to pursue a state law contract or tort claim if he is successful on administrative appeal, this result is implicit in Congress' scheme and cannot be classified as mere happenstance. *Marsaw v. Blue Cross-Blue Shield of Tex. Health Enters., L.L.C.*, 192 F. Supp. 2d 737, 748 (S.D. Tex. 2002); *Marsaw v Thompson*, 133 Fed Appx. 946, 2005 WL 1170445 (5th Cir. 2005) (not designated for publication) ("Congress created a comprehensive statutory administrative review mechanism, which was intended fully to address the problems created by wrongful denial of Medicare reimbursements.").

In *Bodimetric*, the Seventh Circuit reasoned that:

> By enacting the exclusive review provisions of the Medicare Act, Congress expressly limited the remedies that can be sought by dissatisfied claimants from fiscal intermediaries. While this may, in some cases, foreclose avenues of relief generally available

> to civil litigants, it is also the system Congress clearly intended to implement. Any decision to modify this aspect of the system must be made by Congress, not by the courts.

Bodimetric, 903 F.3d at 490.

Moreover, this Court has made clear that the Medicare Act makes no provision for remedies in money damages against officials responsible for unconstitutional conduct that leads to the wrongful denial of benefits. *Schweiker v. Chilicky*, 487 U.S. 412, 424, 108 S.Ct. 2460, 101 L.Ed.2d 370 (1988). The circuit courts have reasoned that "the demand for damages greater than the Medicare statute provides, renders meaningless the jurisdictional restriction of § 405(h)." *Hooker v. U.S. Dept. of Health and Human Servs.*, 858 F.2d 525 (9th Cir. 1988). Accordingly, the state court was precluded from reviewing the propriety of the Medicare denials issued by the Secretary.

Finally, even in cases where the Secretary has reversed the initial claims denials issued by Respondent, a provider is not entitled to any additional damages based on the Medicare contractor's initial denial. *Marsaw*, 133 Fed. Appx. 946, 2005 WL 1170445 (not designated for publication) ("Because Marsaw has now received precisely the Medicare payments he claims were wrongfully denied, and the statute entitles him to no other relief, his case is moot."). Congress established the Medicare appeals process to give providers an opportunity to receive review of erroneously denied

Medicare claims, not to build a case against a Medicare contractor.[22]

Although Petitioner characterizes his complaint as a claim for damages, Plaintiff's complaint is simply a dispute concerning the denial of Medicare claims and alleged supplemental/consequential damages from such denial. Furthermore, Petitioner's concession that he was successful on the administrative review of his claims forecloses any further review and renders his Petition moot.

II. PETITIONER ASKS THE COURT TO CREATE A NEW TOLLING THEORY UNSUPPORTED BY ANY LAW.

Despite Petitioner's firm conviction that his claims are not inextricably intertwined with a claim for Medicare benefits, Petitioner insists that he was required to exhaust the administrative appeals process. Despite a lack of any probative evidence that Petitioner actually completed the appeals process, Petitioner alleges that he was required to engage the review process, and that his alleged participation in this process tolled the limitations on his state law claims. Petitioner's

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[22] Petitioner would use the administrative review process to dispense with any proof that Respondent acted with any malice while denying claims. Petitioner's theory is that no review of his Medicare bills is needed as he had allegedly won "the majority" of administrative reviews. Pet. Br. pp. 10, 18, 19. However, Petitioner does not, and indeed cannot, show how many reviews were successful or that the MAC or any other entity found that Respondent improperly denied, much less denied with malice, any of Petitioner's Medicare claims.

presentation of his claims for judicial review suffers from two defects: 1) as previously discussed, his state law tort claims were inextricably intertwined with a claim for Medicare benefits; and 2) if his state law tort claims were not inextricably intertwined, then they were barred by limitations. In the present dispute, it is impossible for Petitioner to resolve one defect without invoking the other.

In order to overcome this quandary, Petitioner has asked every court that has heard this matter to adopt his novel and unsupported limitations theory. In order to understand this theory, Petitioner's allegations warrant a brief review. Petitioner's allegations seeking liability against BCBSTX in this lawsuit appear essentially to be as follows:

> (1) that Respondent had a scheme that was detectable in 1997, and confirmed in 1998, to inappropriately deny the vast majority of Petitioner's Medicare claims assigned by Medicare enrollees who received the services from Petitioner;
>
> (2) that the foreseeable consequence of denying these Medicare claims was Petitioner's consequential damages (loss of profits, mental anguish, and the like); and
>
> (3) although these consequential damages and related state law claims are not inextricably intertwined with seeking payment for any Medicare claims, for some reason the statute of limitations was tolled

> until all of the Medicare claims had been appealed to their fullest through the administrative process and the federal statute.

Petitioner asks this Court, and every other Court that has heard this dispute, to declare that his claims were not inextricably intertwined with a claim for Medicare benefits, thereby paving the way for Petitioner to recover damages in the wrong court against the wrong defendant, but at the same time his claims were somehow subject to the administrative review process which tolled the statute of limitations and prevented his claims from becoming barred as a matter of law. Neither the law nor logic supports this alarming attempt to avoid Texas limitations law and the Medicare jurisdictional scheme.

Petitioner has inappropriately asked all the courts involved in this matter to make new law on Texas tolling while disregarding settled federal law related to Medicare jurisdiction for physicians and hospital claims. The law is straightforward – Petitioner brought his suit in the wrong court and against the wrong defendant and Petitioner's claims were properly dismissed by the trial court for lack of jurisdiction and preemption. The dismissal was affirmed on the basis of preemption by the court of appeals. If as Petitioner claims, however, these are plain-vanilla state law claims against Respondent, then no limitations tolling should be recognized and Petitioner's state law claims expired prior to this lawsuit being filed in 2003.

CONCLUSION AND PRAYER

Petitioner has failed to demonstrate that there is any split amongst the circuit courts of appeal concerning whether a claim by a Medicare provider for consequential damages that allegedly resulted from the denial of Medicare benefits is inextricably intertwined with a claim for Medicare benefits. In addition, Petitioner has failed to demonstrate that the court of appeals has improperly applied well settled federal law concerning the review and payment of Medicare claims in this matter. Instead, Petitioner has concocted a novel tolling theory without any legal basis in an attempt to prevent the expiration of his claims that relies on the Medicare appeals process. In any event, Petitioner's concession that he has prevailed on the administrative review of his claims renders these issues moot as no further review is available to him.

Respondent respectfully requests that the Court deny the Petition for Writ of Certiorari and affirm the opinion of the court of appeals.

Respectfully submitted,

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In The

Supreme Court of the United States

DR. DRALVES GENE EDWARDS,

Petitioner,

v.

BLUE CROSS BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORP.,

Respondent.

On Petition For Writ Of Certiorari
To The Texas Court Of Appeals
For The Fifth District

REPLY BRIEF

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TABLE OF CONTENTS

	Page
INTRODUCTION	1
I. A Split Among the Lower Court Exists on Whether State Law Remedies Are Preempted under the Medicare Act	4
II. State Law Remedies Are Needed to Redress Fraudulent and Tortious Conduct by Fiscal Intermediaries	5
III. The Administrative Review Process Is Not the Sole Remedy for Fraudulent and Tortious Conduct by Fiscal Intermediaries	9
CONCLUSION	12

TABLE OF AUTHORITIES

Page

CASES

Ackerman v. United Healthcare Serv., Inc., 2009 WL 1769393 (S.D. Miss. 2009) 7

Albright v. Kaiser Permanente Med. Group, 1999 WL 605828 (N.D. Cal. 1999).....6

Altria v. Good, 129 S. Ct. 538 (2008) 6

Ardary v. Aetna Health Plans of Southern California, 98 F.3d 496 (9th Cir. 1996) 5, 11

Bodimetric Health Servs. v. Aetna Life & Cas., 903 F.2d 480 (7th Cir. 1990) 4

City of Worchester v. HCA Mgm't Co., 753 F.Supp. 31 (D. Mass. 1990).....11

Fisher v. United States, 529 U.S. 667 (2000).....6

Group Health Inc. v. Blue Cross Assoc., 625 F.Supp. 69 (S.D.N.Y. 1985) 11

Harris v. Pacificare Life & Health Ins. Co., 514 F.Supp.2d 1280 (M.D. Ala. 2008).....7

Heckler v. Ringer, 466 U.S. 602 (1984) 9, 11, 12

Hofler v. Aetna US Healthcare of Cal., Inc., 296 F.3d 764 (9th Cir. 2002) 11

Jamaica Hosp. Nursing Home v. Oxford Health Plans, 2000 U.S. Dist. LEXIS 13917 (S.D. N.Y. 2000).....11

Kaiser v. Blue Cross of Cal., 347 F.3d 1107 (9th Cir. 2003).....4

TABLE OF AUTHORITIES – Continued

Page

Kelly v. Advantage Health, Inc., 1999 WL 294796 (E.D. La. May 11, 1999) 4, 7, 10, 11

Kennedy v. Health Options, Inc., 329 F.Supp.2d 1314 (S.D. Fla. 2004) 6

Livingston v. Blue Cross of Ala., 788 F.Supp. 545 (S.D. Ala. 1992) 11

McCall v. PacifiCare of Cal., 21 P.3d 1189 (Cal. 2001) 6

Salas v. Grancare, No. 09CA0089 (Colo. App. 1/04/2001) 4

Wartenburg v. Aetna U.S. Healthcare, Inc., 2 F.Supp.2d 273, 280 (E.D.N.Y. 1998) 8

Williams v. Viva Health, Inc., 2008 WL 220799 (M.D. Ala. 2008) 7

Wyeth v. Levine, 129 S. Ct. 1187 (2009) 6

Zolezzi v. PacifiCare of Cal., 129 Cal. Rptr. 2d 526 (Cal. App. 2003) 6

STATUTES

42 U.S.C. § 1395c 7

42 U.S.C. § 1395j 7

43 U.S.C. § 405(g) 11

RULE

S.Ct. Rule 10 5

This case is not about petitioner attempting another run at remedies for respondent's erroneous denial of Medicare claims payments. Rather, this case is about why those denials began in the first place. The distinction between the erroneous denial of Medicare claim payments (which petitioner has already succeeded in proving to an administrative judge) and the erroneous placement of petitioner on 100% prepayment review (which functioned as 100% denial of Medicare payments) is, for purposes of federal preemption, the difference between apples and steak. While a reasonable mind could differentiate between the two, only this respondent would say they are in the same class.

INTRODUCTION

Dr. Dralves Gene Edwards is a board certified family physician in Texas who made house calls on the elderly as well as treated patients in his office. Around 90% of his patients were enrolled in the Medicare program, and he was one of the highest billing doctors to Medicare in the Dallas area.

Respondent, a Medicare fiscal intermediary, placed petitioner on 100% prepayment review without justification and later, denied 100% of petitioner's Medicare claims. In doing so, respondent contravened a number of Medicare guidelines. Respondent conducted a 100% prepayment review without identifying a problem.

The 100% review, combined with the sluggish administrative review process, cost petitioner his medical practice and resulted in many of Dallas' elderly and needy to go without medical care. This was, petitioner believed, the desired result; because respondent needed to cut costs in order to resign a government contract and continue to perform as a Medicare fiscal intermediary. Moreover, the respondent needed to cut costs in order so they could get their government contract renewed as a Medicare fiscal intermediary.

Petitioner ultimately prevailed on 98% of his Medicare claims in the administrative review process, but by then irreparable harm had been done and his medical practice had to close.

To this day, respondent has not provided any answer as to why petitioner was placed on 100% review or an explanation of how a valid prepayment review could result in the closure of a medical practice. Medicare audits and reviews are designed to make sure benefits are paid for services that are covered under Medicare and are reasonable and medically necessary. The review helps to provide uniform national standards for the payment of benefits.

Petitioner brought suit for state law breach of contract, fraud and tort claims and sought consequential damages from the illegal placement on the 100% review and denial list. At issue in the suit, was not the denial of claims themselves, which were

already decided in petitioner's favor by administrative review. The "real issue," was why respondent – contrary to established Medicare guidelines – placed petitioner on the 100% review in the first place. Respondent's Brief In Opposition, at 3 ("Resp.___").

While respondent admits that Blue Cross' decision to place all of petitioner's claims on prepayment review is the "real issue," respondent attempts to dilute the question of whether petitioner's state law claims are preempted by the Medicare Act by parading the fact that petitioner finished the administrative review process. Resp. 3. This fact only aids petitioner's claim against preemption rather than hinders it.

Respondent also brings a long-waived state statute of limitations claim, even though this Court's normal practice is to decide only federal claims properly raised and decided by the courts below. The statute of limitations issue, raised too late in the day, falls through the strainer of this practice.[1]

In the end, respondent cannot counter the fact that the federal preemption question presented has divided the lower courts. Moreover, the question impacts the day-to-day management of health care management by both physicians and Medicare carriers. For these reasons, the Court should grant review.

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[1] The statute of limitations argument was not raised in the court of appeal. Nor was it mentioned by the lower court. As such, it is waived.

I. A Split Among the Lower Court Exists on Whether State Law Remedies Are Preempted under the Medicare Act.

There exists a very real split among lower courts over whether state law remedies are preempted by the Medicare Act. Some courts hold that any state law claims implicating the denial of Medicare benefits are inexplicably intertwined with Medicare and thus, preempted. *See e.g.*, *Bodimetric Health Servs. v. Aetna Life & Cas.*, 903 F.2d 480 (7th Cir. 1990) (holding that state law breach of contract, tortious breach of implied covenant and torts inextricably intertwined); *Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107 (9th Cir. 2003) (contractual claims, constitutional claims, and torts preempted by Medicare Act). Other courts have found that state law remedies implicating Medicare are not inextricably intertwined. *See e.g.*, *Ardary v. Aetna Health Plans of S. Cal.*, 98 F.3d 496 (9th Cir. 1996) (state law wrongful death and negligence claims not preempted); *Salas v. Grancare*, No. 09CA0089 (Colo. App. 1/04/2001) (state law fraud and breach of contract claims not inextricably intertwined); *Kelly v. Advantage Health, Inc.*, 1999 WL 294796 (E.D. La. May 11, 1999).

Respondent urges that these cases are distinguishable because one line of cases involves patients and the other providers. Resp. 18. But that rationale has not been uniformly espoused. In fact, the court in this case concluded that petitioner's state law claims would require an appraisal of the denial of Medicare benefits and based upon that reason, the state law

claims were inextricably intertwined. Pet. App. 17. Moreover, such a distinction by the courts of appeals would be remarkable, given that the express language of the Medicare Act itself applies the same administrative and judicial review requirements to "any individual."

What really divides the lower courts is whether state law claims are available at all, even after administrative review. In this case, the court of appeals held that although petitioner exhausted administrative review and succeeded in vindicating his claims, he could seek no further remedies. Pet. App. 17-18. But the court in *Ardary* expressly rejected this reading of Medicare Act preemption. *Ardary*, 98 F.3d at 498 (rejecting the view that private Medicare representatives cannot be held responsible for tortious acts committed in the context of the denial of Medicare benefits).

Thus, it is clear that the lower courts are experiencing difficulties distinguishing what type of state law claims are "inextricably intertwined" with the Medicare Act. Such division is, of course, a paradigmatic factor warranting this Court's review. S.Ct. Rule 10.

II. State Law Remedies Are Needed to Redress Fraudulent and Tortious Conduct by Fiscal Intermediaries.

This Court has continually noted that the federal government's prosecution of fraud is augmented by

the enforcement of state remedies. *See e.g., Altria v. Good*, 129 S. Ct. 538 (2008); *Wyeth v. Levine*, 129 S. Ct. 1187 (2009). In *Altria*, the Court observed that "[t]he [Federal Trade Commission] has long depended on cooperative state regulation to achieve its mission because, although one of the smallest administrative agencies, it is charged with policing an enormous amount of activity." 129 S. Ct. at 544 n.6. Similarly, in *Wyeth*, the Court explained that state law remedies, such as torts, "serve a distinct compensatory function that may motivate injured persons to come forward with information." 129 S. Ct. at 1202. The Court's emphasis that federal Medicare does not preempt all state law remedies is simply a recognition that in most cases, federal and state law work together to benefit the country.

State fraud and tort laws are no exception to this rule. In many instances, the federal Medicare statute provides no remedy for individuals harmed by Medicare fiscal intermediaries. In such cases, state laws provide the only avenue for relief for the wrongful or fraudulent actions by fiscal intermediaries. For this reason, lower courts have allowed individuals harmed by Medicare plans to rely upon state relief. *See e.g., Kennedy v. Health Options, Inc.*, 329 F.Supp.2d 1314 (S.D. Fla. 2004) (premature release from hospital); *Zolezzi v. PacifiCare of Cal.*, 129 Cal. Rptr. 2d 526 (Cal. App. 2003) (refusal to authorize surgery); *McCall v. PacifiCare of Cal.*, 21 P.3d 1189 (Cal. 2001) (refusal to provide referral to specialist); *Albright v. Kaiser Permanente Med. Group*, 1999 WL 605828 (N.D. Cal. 1999) (refusal to honor referral provided by

plan physician); *Kelly v. Advantage Health, Inc.*, 1999 WL 294796 (E.D. La. 1999) (denial of doctor's request for inpatient hospital admission). State law claims have also been utilized when a managed care plan fraudulently enrolls a beneficiary without his consent. *Ackerman v. United Healthcare Serv., Inc.*, 2009 WL 1769393 (S.D. Miss. 2009). *See also Harris v. Pacificare Life & Health Ins. Co.*, 514 F.Supp.2d 1280 (M.D. Ala. 2008) (misrepresentation that required to enroll in managed care); *Williams v. Viva Health, Inc.*, 2008 WL 220799 (M.D. Ala. 2008) (failure to disenroll).

As Justice Kennedy explained in a case involving federal prosecution for Medicare fraud: "The structure and operation of the Medicare program reveal a comprehensive federal assistance enterprise aimed at ensuring the availability of quality health care for the broader community." *Fisher v. United States*, 529 U.S. 667, 680 (2000); *see also* 42 U.S.C. § 1395c; 42 U.S.C. § 1395j. The availability of quality health care for everyone can only be enhanced by enforcement of state law prohibiting fraud and torts.

This case presents a prime example of how state law can ensure "the availability of quality health care for the broader community." *Fisher, supra*. Here, one of the largest billers to Medicare in the Dallas area and one of the few physicians who made house calls to the elderly was placed on the 100% prepayment review without justification.

A clear example is in Texas, there are 254 counties, of which, 27 have no doctor at all. A large

physician recruitment firm reported in 2005, unfortunately, for the first time, open positions for primary care physicians exceeded searches over specialists. Similarly, medical school graduates choosing family medicine dropped from 2340 in 1997 to 1132 in 2006. The respondent targeted petitioner to improve their profits and retain the Medicare contract. Declining access to medical care will always take second place to profits. Therefore, pushing petitioner out of business did not save lives but increased cost. And because petitioner could only recover the cost of the Medicare payments alone, respondent was not punished for its fraudulent and tortious behavior.

In such cases where no state law remedies exist, fiscal intermediaries have no incentive to act appropriately. Nor can fiscal intermediaries be relied upon to act accordingly on their own, for financial factors will always outweigh community needs. State law remedies are thus needed to compliment federal Medicare law and in no way frustrate the overarching aim of the Medicare statute to facilitate quality health care.

In sum, while the federal Medicare statute provides an avenue for appealing a denial of benefits, state law remedies retain an important role in our cooperative federal-state system of insurance under Medicare. As noted in a wrongful death case, "preemption would seriously infringe upon strong state interests in regulating the quality medical care provided to its citizens." *Wartenburg v. Aetna U.S.*

Healthcare, Inc., 2 F.Supp.2d 273, 280 (E.D.N.Y. 1998). Specifically, for negligent and fraudulent actions, state fraud and tort statutes are vitally important to compensate both physicians and beneficiaries for serious financial loss, bodily harm, and even death, and are necessary to deter Medicare fiscal intermediaries from inflicting such harms on others.

Given the important role that state remedies play in forcing fiscal intermediaries to provide quality medical care to citizens, this Court should grant review.

III. The Administrative Review Process Is Not the Sole Remedy for Fraudulent and Tortious Conduct by Fiscal Intermediaries.

Respondent alleges that the administrative review process was the sole remedy that petitioner could seek. Resp. 19-20. But to make that argument respondent must contort petitioner's claim into one alleging "the denial of Medicare claims." Resp. 21. Thus, respondent implicitly recognizes that if petitioner's claim does not challenge the denial of benefits, it is not inextricably intertwined with Medicare and other state law remedies can be pursued.

As one district court held:

> Nothing in *Heckler* compels a reading of the phrase "arising under" to encompass all state-law claims that relate to a denial of benefits. Unlike the plaintiffs in *Heckler*, petitioner's claims do not "at bottom" seek

> reimbursement of Medicare benefits. In fact, plaintiff eventually received all of the requested benefits during . . . hospitalization. There are no Medicare benefits to be reimbursed or provided either now or in the future. Rather, plaintiff seeks damages for state law torts, which he alleges were inflicted by defendants as a result of their delay in granting the requested benefits. Moreover, contrary to defendants' assertion, the test for determining whether the claim arises under the Act is whether it is "inextricably intertwined" with a claim for benefits, not with the Act itself. Here, plaintiff is not seeking Medicare benefits, and thus his state law tort claims are not "inextricably intertwined" with a claim for Medicare benefits.

Kelly v. Advantage Health, Inc., 1999 WL 294796 at *12-13 (E.D. La. 1999).

This case virtually mirrors that in *Kelly*. Petitioner does not seek damages relating to the erroneous denial of Medicare claims, for he has already won that battle in the administrative review process. Thus, there are no Medicare reimbursement payments coming now or in the future. Instead of Medicare payments, petitioner seeks damages relating to the erroneous decision by respondent to place petitioner on the 100% prepayment review. And because petitioner does not seek benefits, his claim cannot be inextricably intertwined with the Medicare Act.

Respondent's assertion that petitioner's claim is distinguishable from the number of state law claims found not preempted, because those cases involved suits by patients rather than providers, is also misplaced. Resp. 18. First, nothing in the Medicare Act even remotely makes such a distinction. To the contrary, the Act applies the same administrative and judicial review process to "any individual." 43 U.S.C. § 405(g). In addition, if the distinction between patient and provider is the deciding factor between a claim inextricably intertwined with Medicare and one that is not, then patients could simply forego the administrative review process altogether, bringing erroneous benefits claims straight to court without preemption standing in the way. Nothing in *Heckler v. Ringer*, 466 U.S. 602 (1984), or the Medicare Act commands such a result.

Ultimately, respondent's argument – like that by the court below – cannot reasonably distinguish petitioner's case from the number of claims not requesting Medicare payments or benefits that have been allowed to go forward. *See e.g., Hofler v. Aetna US Healthcare of Cal., Inc.*, 296 F.3d 764 (9th Cir. 2002); *Ardary v. Aetna Health Plans of Southern California*, 98 F.3d 496 (9th Cir. 1996); *Kelly, supra*; *Livingston v. Blue Cross of Ala.*, 788 F.Supp. 545, 548 (S.D. Ala. 1992); *City of Worchester v. HCA Mgm't Co.*, 753 F.Supp. 31, 38 (D. Mass. 1990); *Group Health Inc. v. Blue Cross Assoc.*, 625 F.Supp. 69, 76 (S.D. N.Y. 1985); *Jamaica Hosp. Nursing Home v. Oxford Health Plans*, 2000 U.S. Dist. LEXIS 13917 (S.D.N.Y. 2000).

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CONCLUSION

This Court is presented with a question that has divided lower courts and impacts daily, the operation of this country's healthcare system. Also, the lower courts' treatment of petitioner's state law claims conflicts with both Congressional preference and this Court's decision in *Heckler*. For these reasons, review is warranted.

Respectfully submitted,

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